

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital, and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12001

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 12001

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Alder, Julia

2. DATE AND HOUR OF DEATH

Nov. 29 '68 12:42 PM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Sinai Hosp. of B
424. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Md. Baltimore 5300

C. CITY OR TOWN

Pikesville 8

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

117 Village Rd.

5. SEX

F

6. RACE

W

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

May 17 '08

9. AGE (In years
last birthday)

70

If Under 1 Yr.

Months: Days: Hours: Min.

If Under 24 Hrs.

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State of foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL
SECURITY NO.

unknown

17. INFORMANT

Mrs. Helen V. Schultz 17 Village Rd.

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Diabetes Mellitus

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 26 '68 19 to Nov. 29 19 68
that (I) (we) last saw the deceased alive on Nov. 28 8:00 PM '68 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Hyun T. Oh

DEGREE

Attending ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

Nov. 29 '68

23C. PHYSICIAN'S
NAME (Type)

HYUN T. OH

DEGREE

23D. ADDRESS

Sinai Hosp. of Balt.

24A. BURIAL CREMATION, 24B. DATE
REMOVAL (Specify)

Burial Dec. 2, 1968

24C. NAME of CEMETERY or CREMATORY

Wood Ridge Cemetery

24D. LOCATION

Pikesville, Balt.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 4 1969

25B. NAME OF REGISTRAR

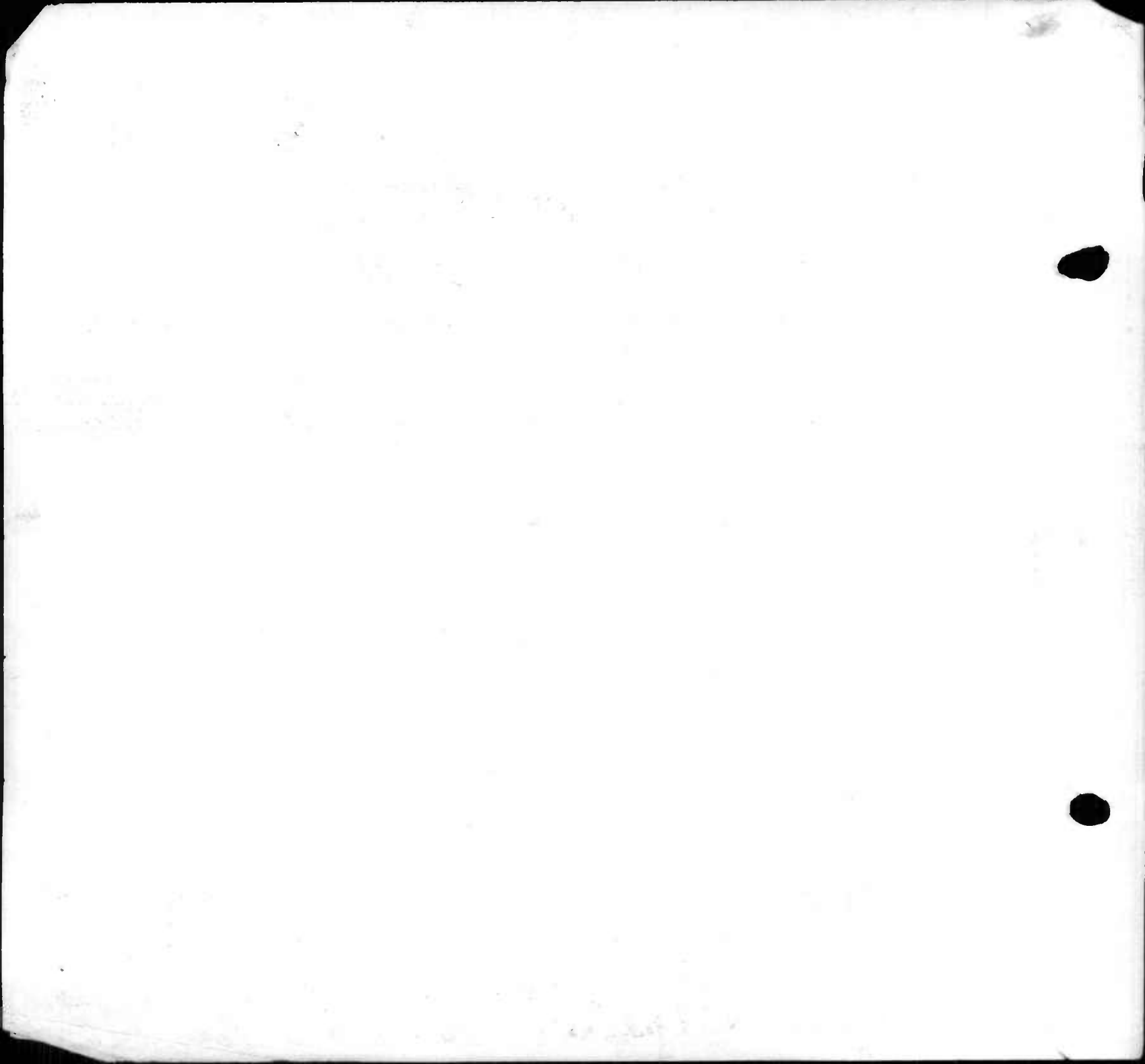
J. E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Frank A. Russell

ADDRESS

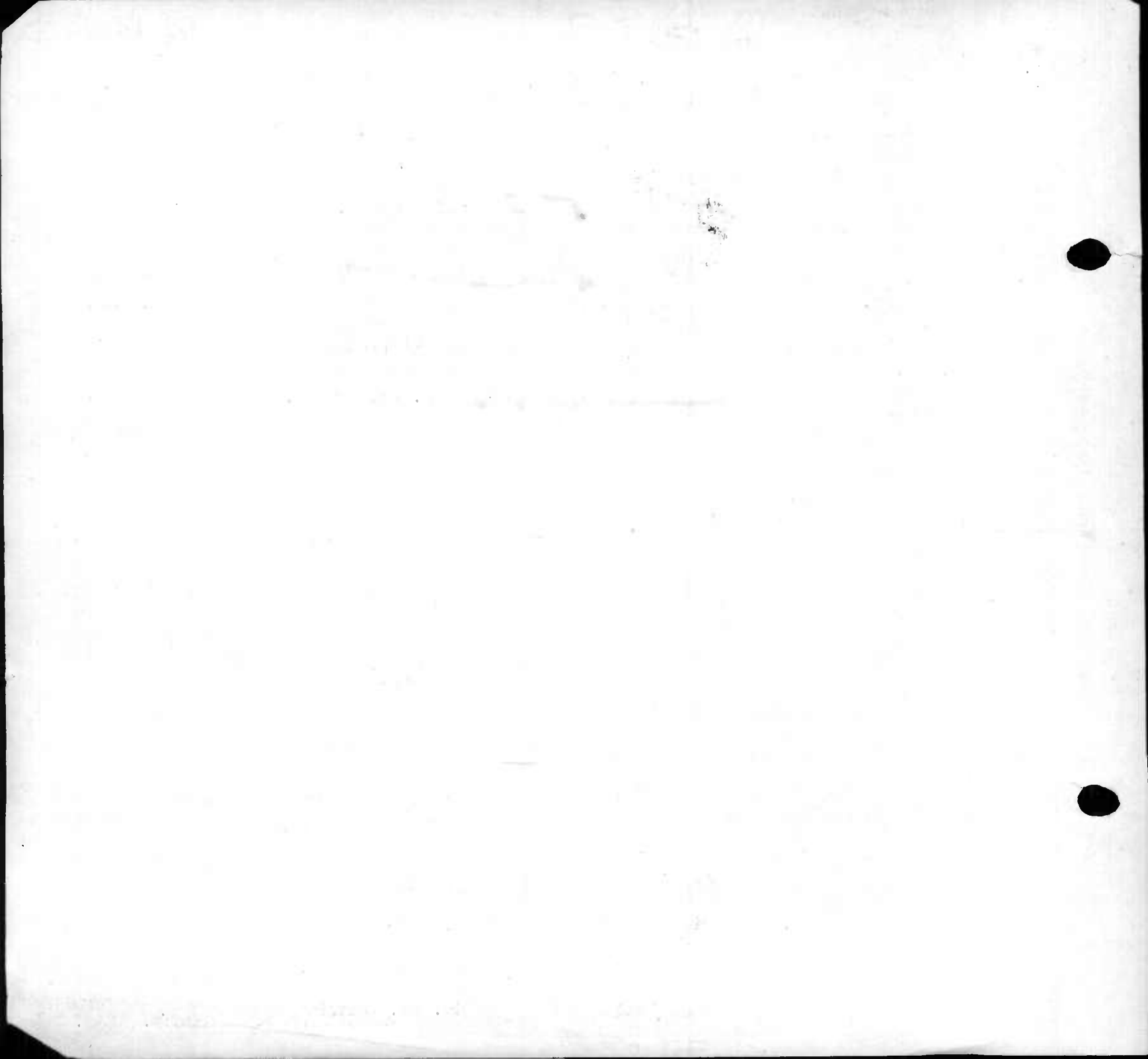
Pikesville 8, Md.



FUNERAL DIRECTOR: IMPORTANT

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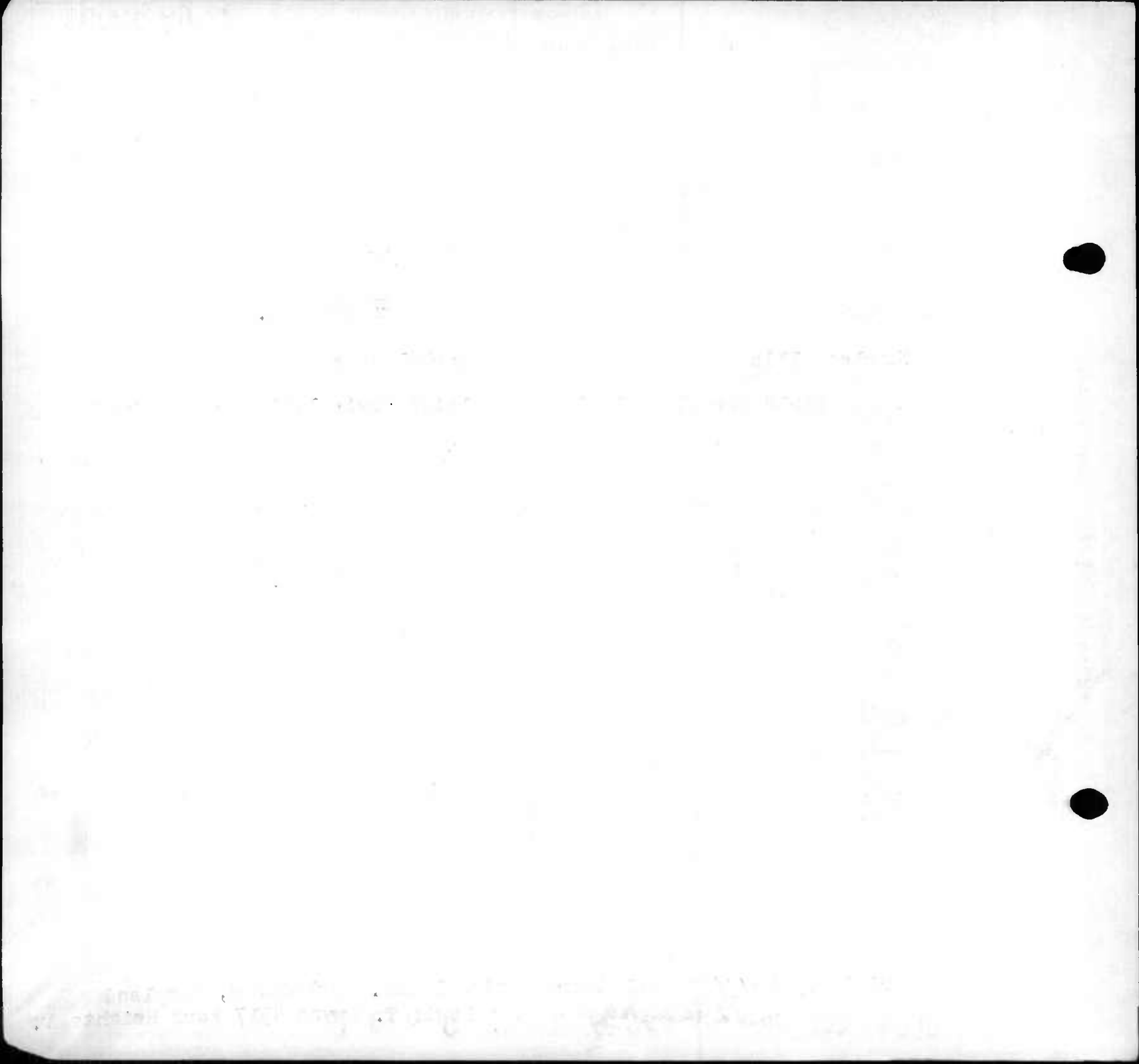
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12002
BIRTH NO. 69 12002		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Mariano G. Cordi		2. DATE AND HOUR OF DEATH 12-3-1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Pleasant Manor Nursing Home		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Pleasant Manor Nursing Home		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-12-1884		9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Contractor		10B. KIND OF BUSINESS OR INDUSTRY Contracting		11. BIRTHPLACE (State or foreign country) Italy
13. FATHER'S NAME Guiseppe Cordi		14. MOTHER'S MAIDEN NAME Mary Traina		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 133-14-5064		17. INFORMANT Dr. Joseph M. Cordi
				ADDRESS Same
18. 710.9 I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		MASSIVE MYOCARDIAL INFARCTION		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from May 3 1966 to Dec 1 1969 , that (1) (we) last saw the deceased alive on 11/18 1969 and that in my (aur) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.				
23A. SIGNATURE W. M. Smith M.D.				23B. DATE SIGNED 12/3/69
23C. PHYSICIAN'S NAME (Type) Dr. Meredith Smith		23D. ADDRESS 6305 The Alameda		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-5-1969		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park
				24D. LOCATION Baltimore County, Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 4 1969		25B. NAME OF REGISTRAR W. E. Fisher, M.D.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.
				ADDRESS 4905 York Road Balto., Md.



FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 69 12003	
<div style="display: flex; justify-content: space-between;"> E-420 69 12003 CERTIFICATE OF DEATH </div>					
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)	
				Rudolph Ellis	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
12/6/69 4:20 A.M.		48 Maryland General Hosp.			
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			
A. STATE MD		1401			
B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Balto			
D. STREET ADDRESS (If rural, give location)		890 Linden Ave.			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH 2/1/23	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Unemployed				XXXX Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME			
USA		Charles Ellis			
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
Rachel Howe		Yes World War II			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
215 16 2025		Elaine Bowie 1833 Lorman Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
426X I		LARYNGEAL CANCER - 12 MONTHS		DAYS	
ANTECEDENT CAUSES		(A) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		PULMONARY THROMBOSIS, MASSIVE		105	
		(B) DUE TO		495	
		(C) " HYPERTENSION			
		(D) " THROMBI, MULTIPLE, OLD		495	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CHROMIUM CONCENTRATIONS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/6/69 to 12/6/69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael G. Lewis M.D.				23B. DATE SIGNED 12/6/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/5/69		Baltimore National Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 4 1969		Robert E. Taylor		Lewis, T. Gwynn	
4517 Park Heights Ave					



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BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ALLIE GRAY SWAGGERTY

2. DATE AND HOUR OF DEATH

DECEMBER 2, 1969

4:28 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1007 S. Charles Street 21230 007

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

7-26-04

9. AGE (In years
last birthday)

65

11 Under 1 Yr.
Months: Days:11 Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Floor Worker

10B. KIND OF BUSINESS OR INDUSTRY

Box Co.

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Charles Thompson

14. MOTHER'S MAIDEN NAME

Mary Porters

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

232-48-4615

17. INFORMANT

4940 Eastern Avenue
BCH-Records Baltimore, Maryland 21224

ADDRESS

18.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE SQUAMOUS CARCINOMA OF CERVIX
DUE TO, OR AS A CONSEQUENCE OF:(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

4 YR.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

DIABETES MELLITUS

YEARS

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from FEBRUARY 23, 19 68 to DECEMBER 2, 19 69
that (1) (we) last saw the deceased alive on DECEMBER 2, 19 69 and that (1) (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Michael M. Mc Connell, M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

DECEMBER 2, 1969

23C. PHYSICIAN'S
NAME (Type)

Michael M. Mc Connell

MD

23D. ADDRESS

4940 Eastern Avenue
BCH- Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12 5 69

24C. NAME OF CEMETERY or CREMATORY

Glen Haven

24D. LOCATION

Glen Burnie, A. A. Co. Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 4 1969

25B. NAME OF REGISTRAR

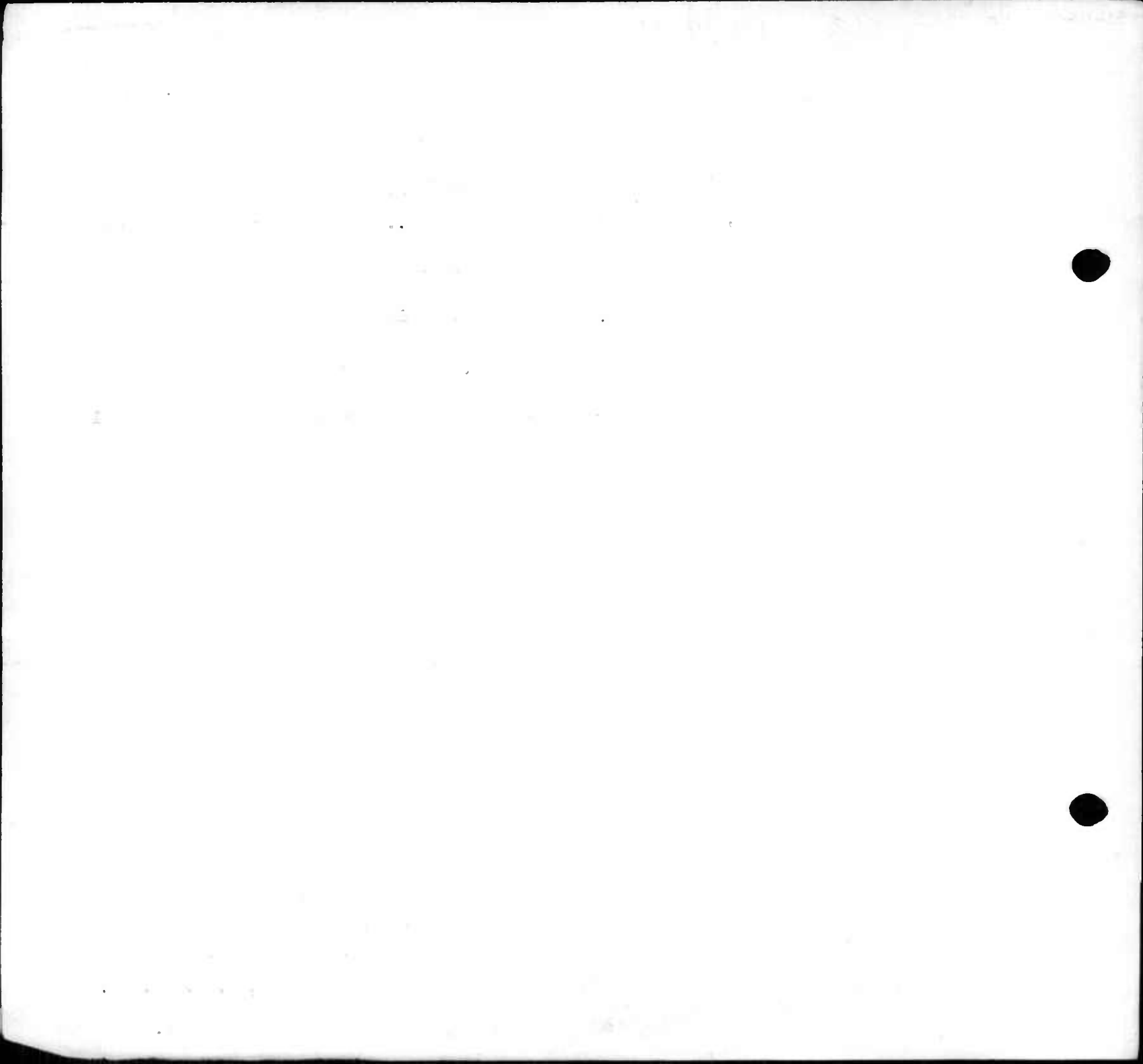
John E. Kelly

25C. FUNERAL DIRECTOR

Mc Cully

ADDRESS

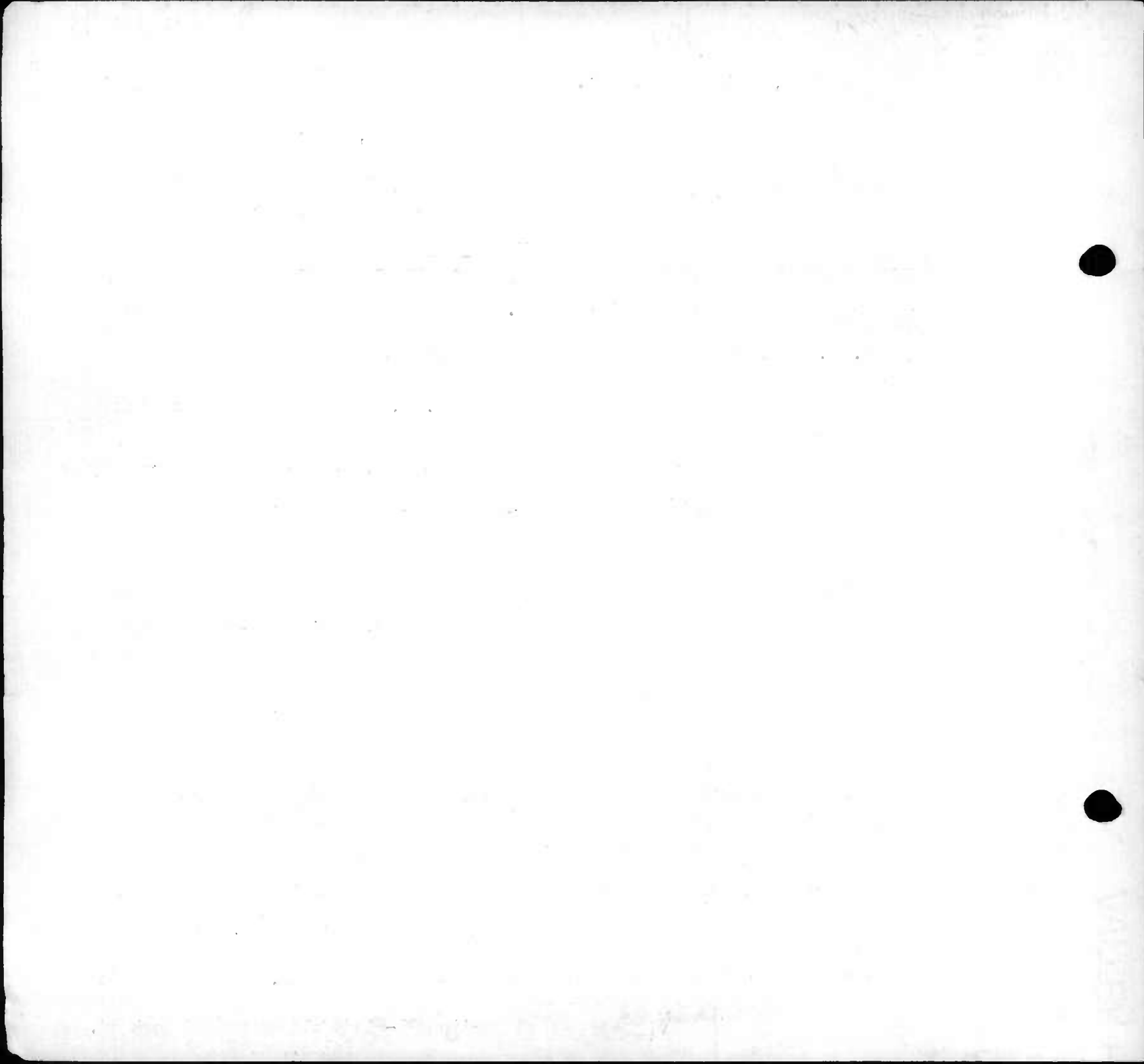
130 E. Fort Ave



FUNERAL DIRECTOR: IMPORTANT

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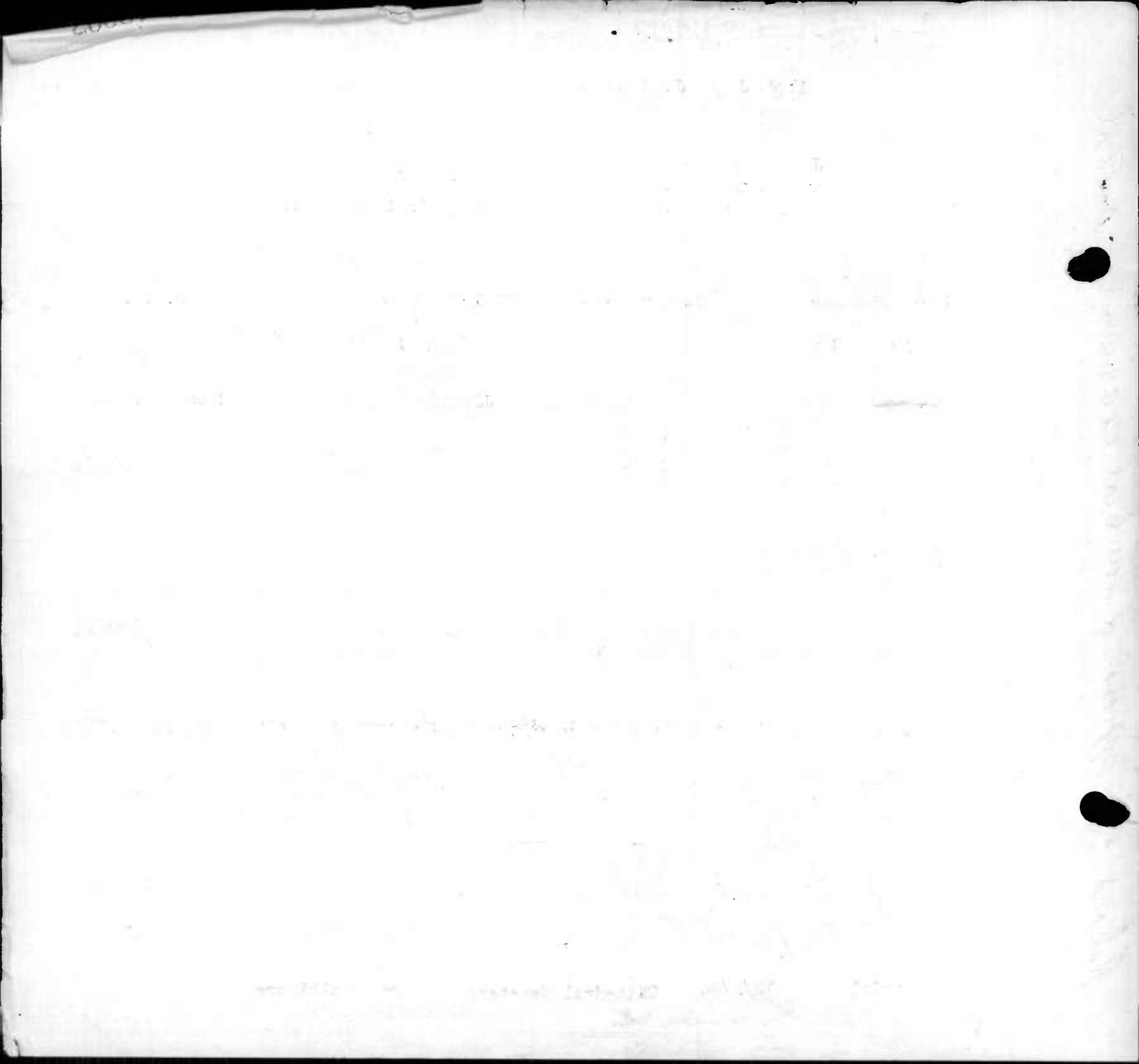
T-460		69 12005		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12005	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Taylor, Miss Florence M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Keswick 700 West 40th Street				2. DATE AND HOUR OF DEATH 11/24/69 8:40 A.M.			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore, Maryland B. COUNTY 1307				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 700 West 40th Street							
5. SEX Female		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-12-72	
9. AGE (In years last birthday) 97		If Under 1 Yr. Months: Days: Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Martin Gillett Co.	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John H. H. Taylor				14. MOTHER'S MAIDEN NAME Martha Anne Green			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 218-15-8899		17. INFORMANT Mrs. T. Gott RN	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Encephalomalacia arteriosclerosis, generalized 4 years Blindness due to glaucoma 1951				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II Blindness due to glaucoma 1951							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1966 to 11/24/69 that (I) (we) last saw the deceased alive on 11/24/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE W. B. Daniels, Jr. M.D.				23B. DATE SIGNED 11/24/69			
23C. PHYSICIAN'S NAME (Type) W. B. Daniels, Jr. M.D.				23D. ADDRESS Keswick Home, Baltimore, Md, 21211			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 11/26/69		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Maryland	
25A. NAME OF REGISTRAR Mitchell Niedefeld				25C. FUNERAL DIRECTOR ADDRESS 6500 York Rd, Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

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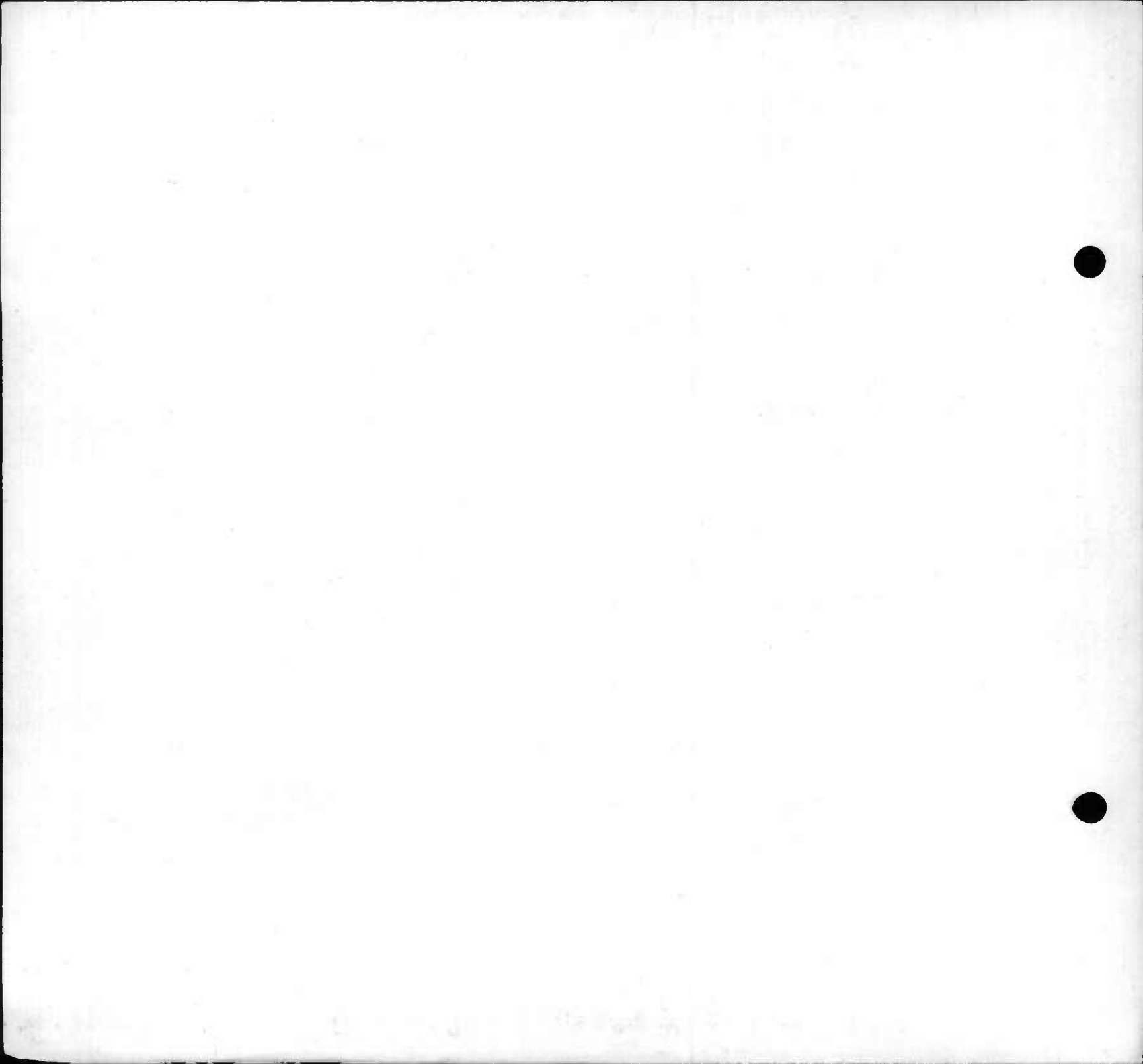
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12006	
5-130 69 12006		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Ruth C. Spott		November 30, 1969 <i>12:45 am</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 528 Walker Avenue- Apt. A		A. STATE Maryland B. COUNTY 2768	
		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 528 Walker Avenue	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 16, 1900
		9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John L. Hugg		14. MOTHER'S MAIDEN NAME Laura V. Hipp	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-01-5470 B	
		17. INFORMANT Mr. Herbert A. Spott, Sr.	
		ADDRESS	
18. 4-360 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF: (B) Essential hypertension DUE TO, OR AS A CONSEQUENCE OF: (C) 10 yrs	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 19 1959 to Nov 30 1969 , that (I) (we) last saw the deceased alive on Nov 14 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <i>W. Allan Spier</i>		23B. DATE SIGNED 12/1/69	
23C. PHYSICIAN'S NAME (Type) Allan Spier		23D. ADDRESS M.D. 1501 Pentridge Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/3/69	
24C. NAME OF CEMETERY or CREMATORY Greenmount Cem.		24D. LOCATION (City, town, or county) (State) Baltimore	
25A. DATE REC'D BY HEALTH DEPT. DEC 4 1969		25B. NAME OF REGISTRAR Mitchell Wiedefeld	
25C. FUNERAL DIRECTOR ADDRESS Home-6500 York Rd. 12			



FUNERAL DIRECTOR: IMPORTANT

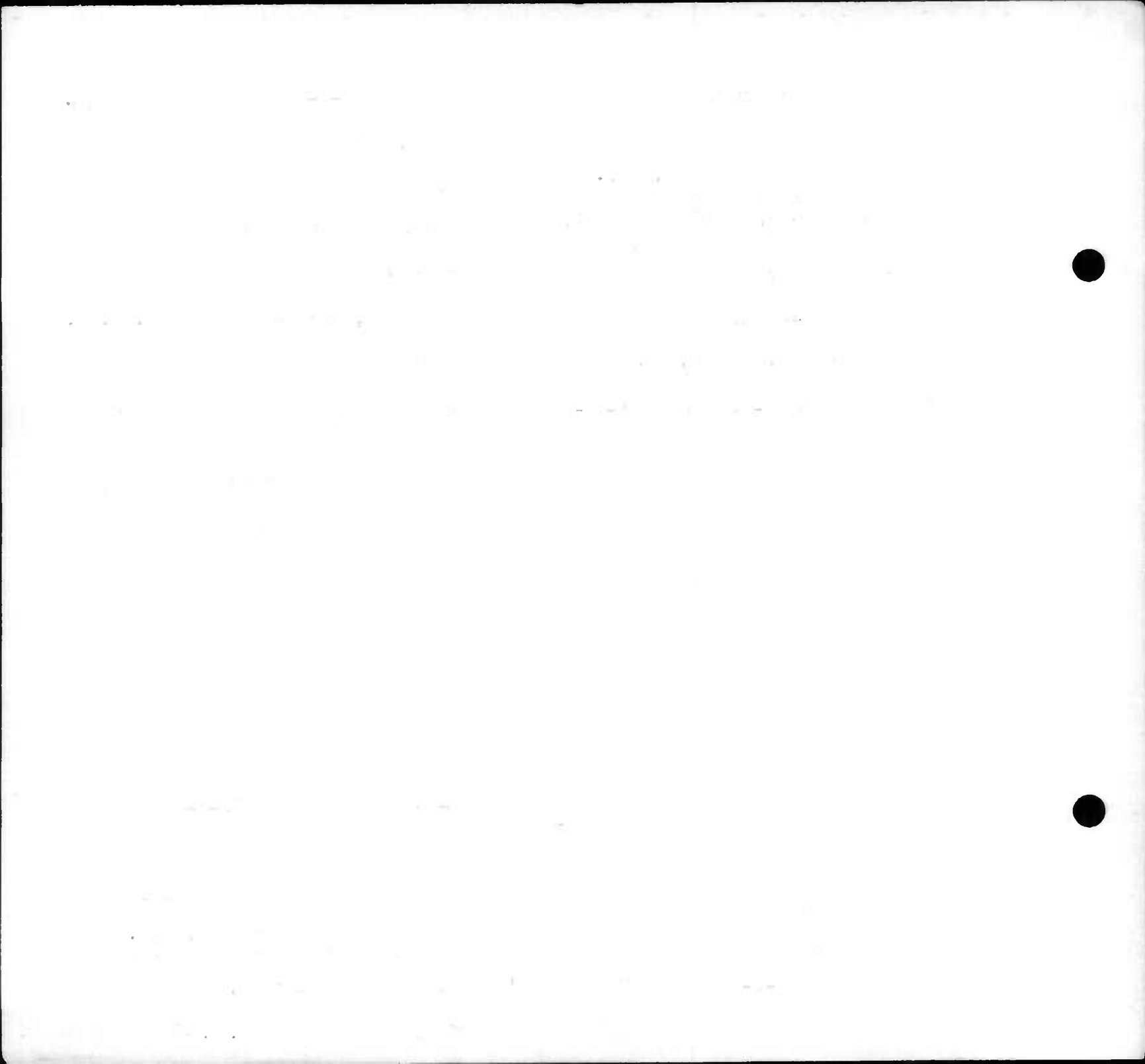
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-520		69 12008		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12008	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Charles E. Jones</u>				12. 2. 69 7:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>66 Lutheran Hospital</u>				A. STATE <u>B. COUNTY</u>		C. CITY OR TOWN	
				<u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER				5129 Sekots Rd.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
<u>Male</u>	<u>Negro</u>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<u>12-16-33</u>	<u>35</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Guard</u>		<u>U.S. Coast Guard</u>		<u>Litleton, N. Carolina</u>		<u>U.S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Charles Jones</u>				<u>Rosella Jones</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<u>Yes. 8/11/51 - 12/23/54</u>						<u>Mrs. Mary G. Jones 5129 Sekots Rd.</u>	
18. <u>442 X I</u>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				<u>Cardio Respiratory Failure</u>			
ANTECEDENT CAUSES				(B) <u>Immediate Post Op.</u>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <u>(Intra Cranial Aneurysm - Int. Carotid Left)</u>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<u>12. 2. 69.</u>		<u>Aneurysm Int. Carotid</u>		<input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
<input type="checkbox"/>							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from <u>11. 2A</u> <u>19 69</u> to <u>12. 2</u> <u>19 69</u> , that (I) (we) last saw the deceased alive on <u>12. 2</u> <u>19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
<u>Blumhman</u>							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
<u>HAHRER AHMAD KHAN</u>				<u>Lutheran Hosp. of MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/8/69</u>		<u>Lodi Cemetery</u>		<u>Lodi, New Jersey</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<u>DEC 4 1969</u>		<u>Charles E. Jones</u>		<u>Dyett F.H.</u>		<u>1701 Laurens</u>	



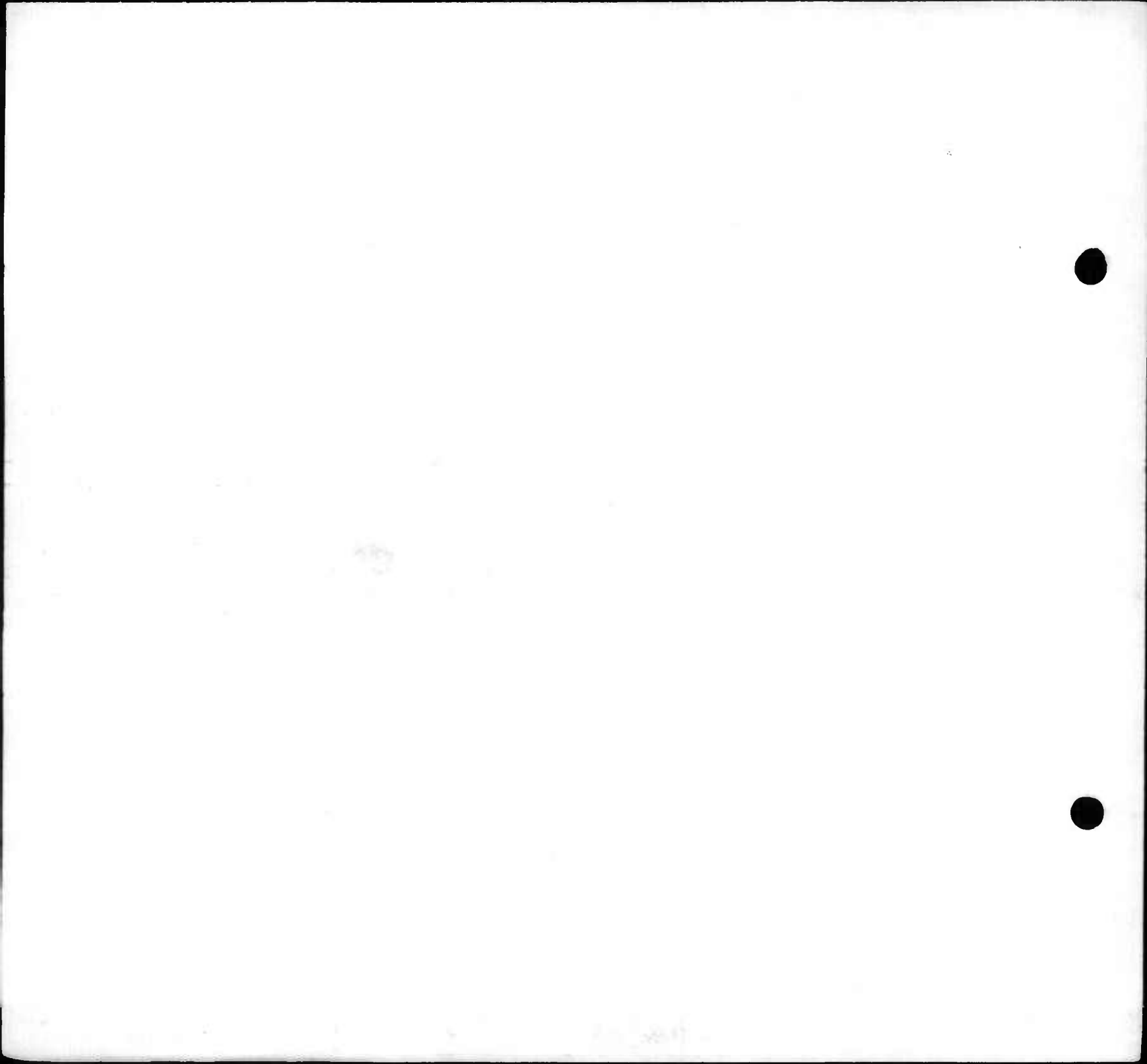
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-632		69 12009		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12009	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <u>James Curtis</u>				2. DATE AND HOUR OF DEATH <u>12-2-69</u> <u>1:45</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Provident Hospital, Inc.</u> <u>1514 Division Street</u> <u>Baltimore, Maryland 21217</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1303</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2422 Madison Avenue</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-20-20</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>American Smelting</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>James L. Curtis, Sr.</u>			14. MOTHER'S MAIDEN NAME <u>Cassandra Curtis</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <u>3/25/43-2/15/46</u>			16. SOCIAL SECURITY NO. <u>215-18-6581</u>		17. INFORMANT <u>George Curtis</u>		
18. <u>400.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Malignant Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u> <u>6 mos</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-1-69</u> 19 to <u>12-2-69</u> 19 that (I) (we) last saw the deceased alive on <u>12-2-69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>G. Franklin Phillips M.D.</u>				23B. DATE SIGNED <u>12-2-69</u>		23C. PHYSICIAN'S NAME (Type) <u>G. Franklin Phillips M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-5-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat'l Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 4 1969</u>		25B. NAME OF REGISTRAR <u>John E. Satterly R.E.</u>		25C. FUNERAL DIRECTOR <u>MORTON & DYETT F.H.</u>		ADDRESS <u>1701 Laurens St.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

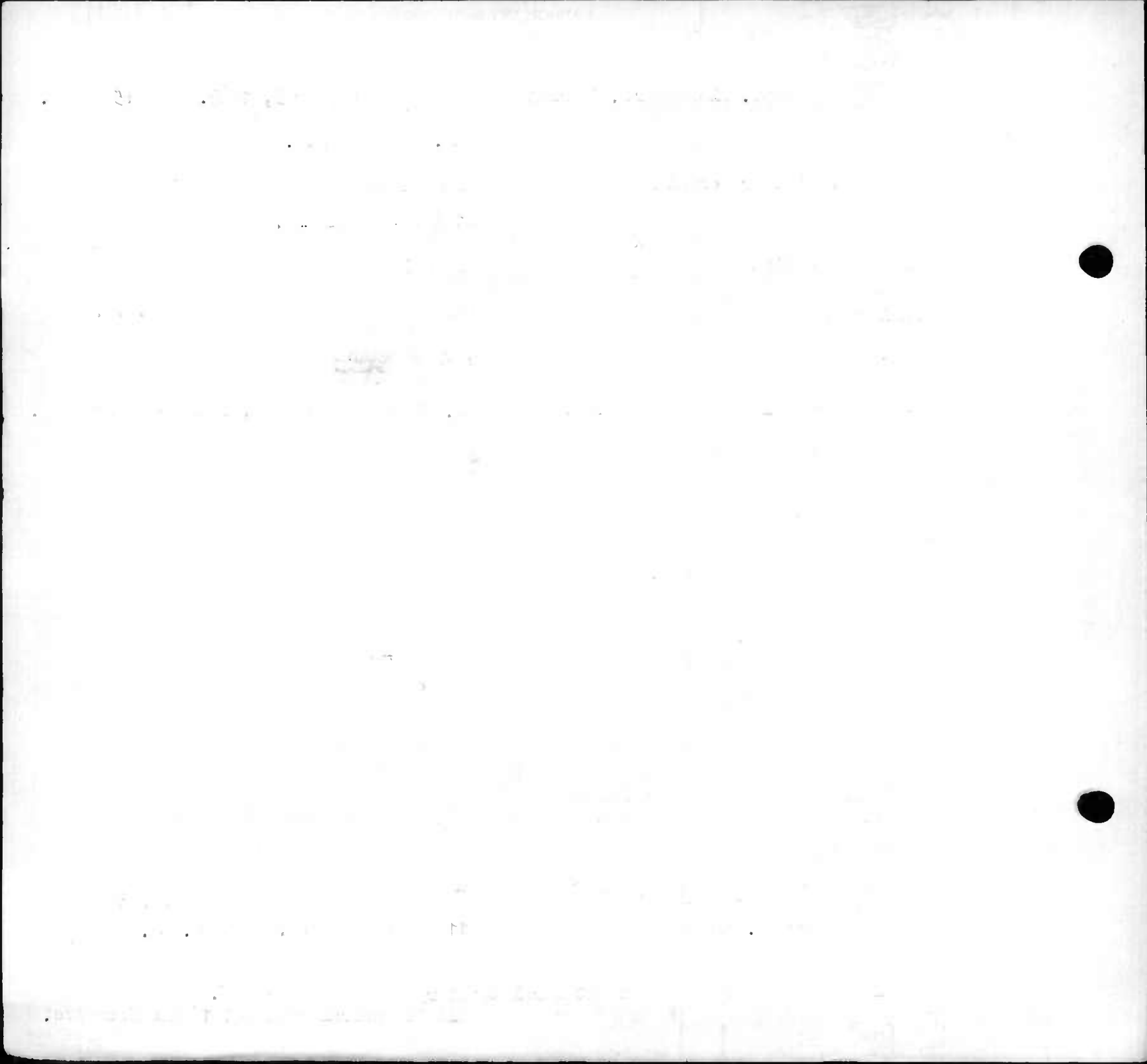
5-352		69 12010		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12010	
1. NAME OF DECEASED (Type or Print) <u>Mrs. Roxie Stinson</u>				2. DATE AND HOUR OF DEATH <u>12-2-69</u> <u>7:10 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>34 Bon Secours Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>21223 2001</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1812 W. Fayette St.</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-25-97</u>	9. AGE (in years last birthday) <u>72</u>	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Dallas Moore</u>				14. MOTHER'S MAIDEN NAME <u>Martha Moore</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Howard Spinney</u>		ADDRESS <u>2902 W. Lanvale</u>	
18. <u>412.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral hemorrhage</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
				(B) <u>Hypertensive + Arteriosclerotic Cerebrovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF: <u>years</u>		(C) <u>Hypertensive + Arteriosclerotic Ht. Disease</u> <u>years</u>	
19A. DATE OF OPERATION <u>12/2</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?				22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>12/2/1969</u> to <u>12/2/1969</u> that <u>(X)</u> (we) last saw the deceased alive on <u>12/2/1969</u> and that <u>(X)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>M. Abbas M.D.</u>				23B. DATE SIGNED <u>12/2/69</u>		23C. PHYSICIAN'S NAME (Type) <u>M. Abbas M.D.</u>	
23D. ADDRESS <u>Bon Secours Hospital</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>12/2/69</u>				24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>			
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>DEC 4 1969</u>			
25B. NAME OF REGISTRAR <u>John E. Taylor</u>				25C. FUNERAL DIRECTOR <u>John E. Taylor</u>			
25D. ADDRESS <u>1701 Laurens St</u>							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12011	
E-562 69 12011				CERTIFICATE OF DEATH	
BIRTH NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Capt. Alexander L. Emerson				December 3, 1969 6:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secour Hospital				A. STATE Md. B. COUNTY Balto.	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4104 Edmondson Ave.	
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/95	9. AGE (In years last birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME William		
14. MOTHER'S MAIDEN NAME Mary Donelan			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 9/17/18-1/27/19		
16. SOCIAL SECURITY NO. 217-38-2436			17. INFORMANT ADDRESS Mrs. Alexander Emerson, 4104 Edmondson Ave.		
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Coronary artery sclerosis			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary artery sclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis Cardio Vase. Disease (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 18, 1967 to Dec 3, 1969 , that (I) (we) last saw the deceased alive on Dec 3, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Harry L. Knipp</i>				23B. DATE SIGNED 12/4/69	
23C. PHYSICIAN'S NAME (Type) Harry L. Knipp				23D. ADDRESS 4116 Edmondson Ave. Balto. Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/69		24C. NAME OF CEMETERY or INTERMENT New Cathedral Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969			
25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR Witzke Funeral Home		25D. ADDRESS 4101 Edmondson Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-615 BIRTH NO. 1. NAME OF DECEASED (Type or Print)		69 12012 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12012	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 2em; float: left; margin-right: 10px;">40</div> ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229			2. DATE AND HOUR OF DEATH NOVEMBER 30, 1969 5:45A. M.		
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10B. KIND OF BUSINESS OR INDUSTRY WESTINGHOUSE		8. DATE OF BIRTH 01/15/20	
13. FATHER'S NAME JAMES R TAYLOR		14. MOTHER'S MAIDEN NAME LILLIAN Fogg		9. AGE (In years last birthday) 49	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-01-9655		11. BIRTHPLACE (State or foreign country) MARYLAND	
17. INFORMANT ST AGNES HOSPITAL'S RECORDS		12. CITIZEN OF WHAT COUNTRY? U.S.A.		10. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY MARYLAND BALTIMORE	
13. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 320 GRALAND ROAD	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 35%;"> (A) IMMEDIATE CAUSE <i>Bacterial Meningitis</i> DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 12-3-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED YES		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 29 19 69 to NOVEMBER 30 19 69 that (X) (we) last saw the deceased alive on NOVEMBER 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE 				23B. DATE SIGNED 11 30 69	
23C. PHYSICIAN'S NAME (Type) SALVADOR QUIROZ M.D.				23D. ADDRESS CATON & WILKENS AVES. BALTO MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-3-69		24C. NAME OF CEMETERY or CREMATORY Woodlawn	
24D. LOCATION (City, town, or county) (State) Woodlawn Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR E. J. Taylor, M.D.	
25C. FUNERAL DIRECTOR Higginbotham Slack		25D. ADDRESS Ellicott City, Md. 21043		25E. ADDRESS Ellicott City, Md. 21043	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>R-500 69 12013 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12013</p>	
<p>BIRTH NO.</p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>1. NAME OF DECEASED (Type or Print) <u>Ryan, Glenn</u></p>		<p><u>11/28/69</u> <u>3:00 AM.</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Harbor View Nursing Home & CC</u> <u>1213 Light St. Baltimore</u></p>		<p>A. STATE <u>Maryland</u> B. COUNTY <u>Howard</u></p>	
		<p>C. CITY OR TOWN <u>Box 262 KITT CAT Rd.</u></p>	
		<p>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
		<p>E. STREET AND NUMBER</p>	
<p>5. SEX <u>M</u> 6. RACE <u>W</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 22, 1917</u></p>	
<p>9. AGE (In years last birthday) <u>52</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maint. Mechanic</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>West Virginia</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>	
<p>13. FATHER'S NAME <u>Glenn, Perry</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Linda Wetzel</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>?</u></p>	
<p>17. INFORMANT <u>Ada Clements</u></p>		<p>ADDRESS <u>8518 Harwood Rd</u> <u>Ellicott City Md</u></p>	
<p>18. CAUSE OF DEATH</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p><u>Carcinoma of Lung - metastatic</u></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>		<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> 19 <u>69</u> to <u>11/28</u> 19 <u>69</u>, that (I) (we) last saw the deceased alive on <u>11/14</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date <u>11/28</u> and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Joseph S. Blum</u></p>		<p>23B. DATE SIGNED <u>11/28/69</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>JOSEPH S. BLUM MD</u></p>		<p>23D. ADDRESS <u>1115 N. CALVERT ST</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>12-1-69</u></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <u>MEADOWEDGE PARK</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Ellicott City, Howard Md</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1969</u></p>		<p>25B. NAME OF REGISTRAR <u>Robert E. Sabin, M.D.</u></p>	
<p>25C. FUNERAL DIRECTOR <u>Robert E. Sabin, M.D.</u></p>		<p>ADDRESS <u>Ellicott City Md 21043</u></p>	

Address is Ellbridge, Md.

Stack - Higinbotham Funeral Home.

CT

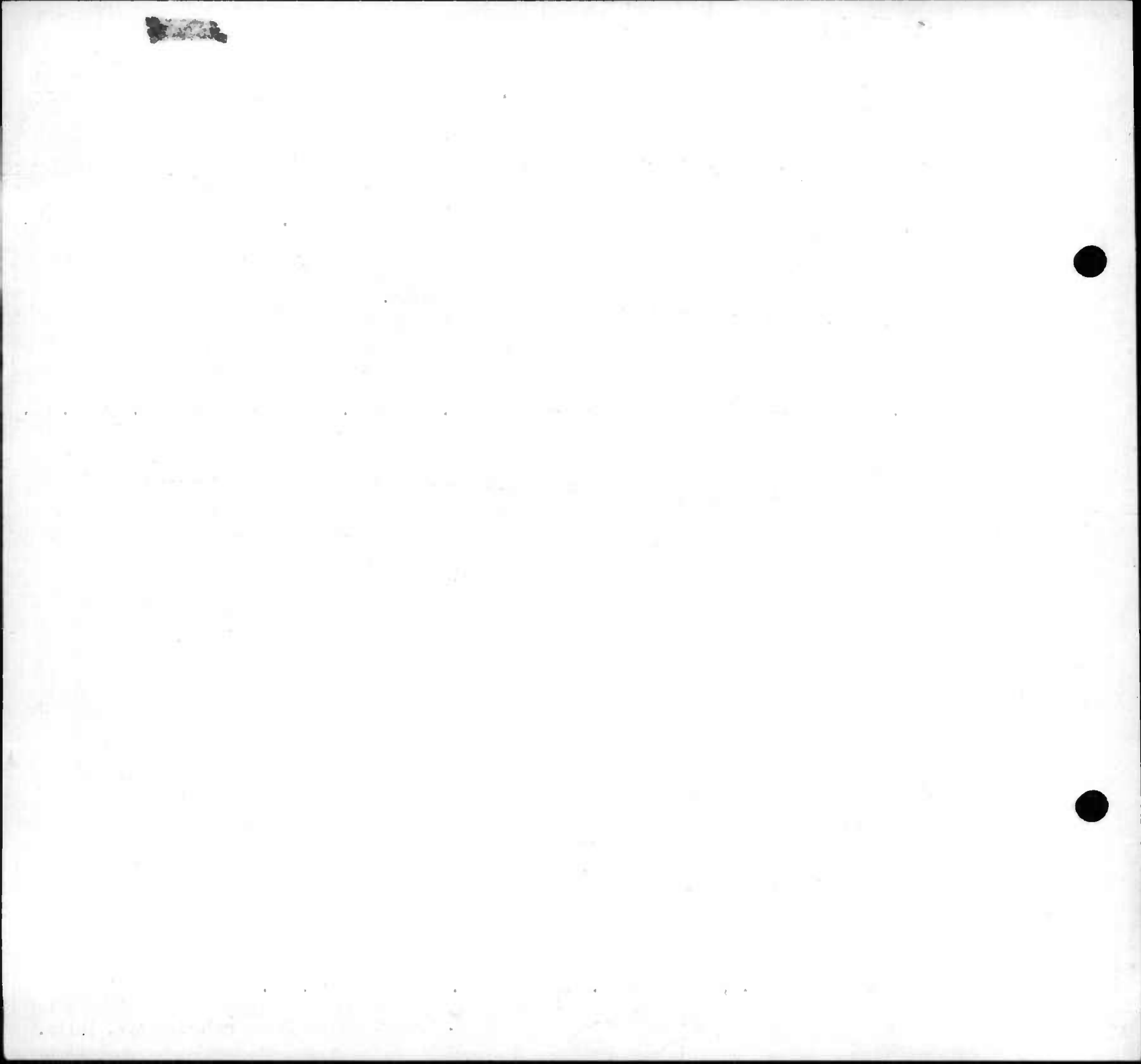
12/23/69 - Correction form from funeral director.

ABC

FUNERAL DIRECTOR: IMPORTANT

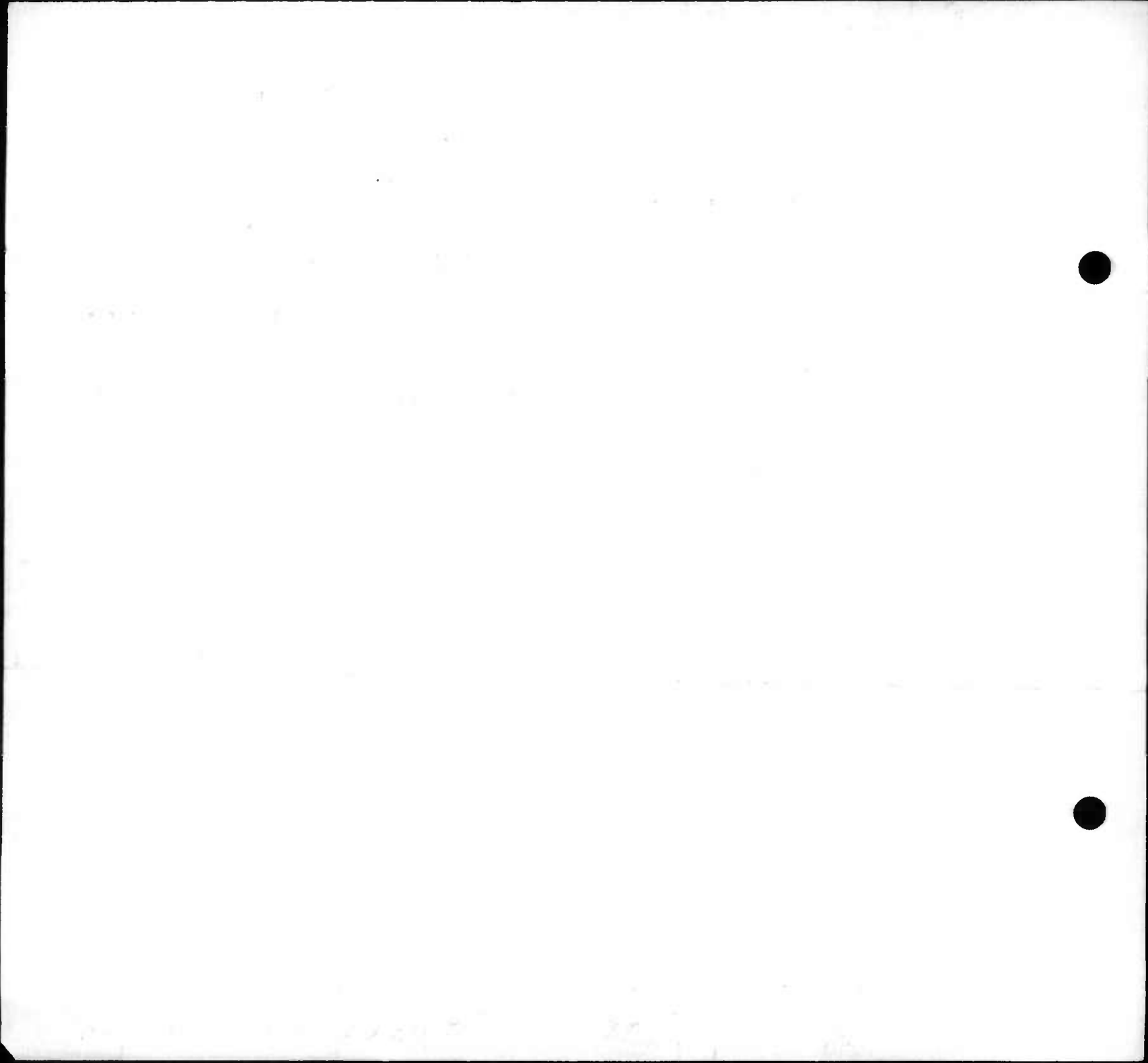
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-550		69 12014		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]		69 12014	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Lanahan, William J.</u>				2. DATE AND HOUR OF DEATH <u>11-30-69</u> <u>5⁰⁰ A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>Balti.</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>HARBOR VIEW N.C.C.</u>						C. CITY OR TOWN <u>Balti.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3215 STAFFORD ST.</u>						F. STREET AND NUMBER <u>3215 Stafford St.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-14-09</u>	9. AGE (In years lost birthday) <u>60</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE LISTED</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Electrician</u>		11. BIRTHPLACE (State or foreign country) <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <u>Mary Stewart nee</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes.</u> <u>1942-1945</u>				16. SOCIAL SECURITY NO. <u>213-01-9354</u>		17. INFORMANT <u>Mrs. Thelma B. Blair</u>		ADDRESS <u>2406 Crest Rd. Balto. Md.</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>238.11</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Chronic Brain Syndrome</u>						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Broucho-Pneumonia</u> <u>6d.</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Brain Tumor</u> <u>1 yr.</u>	
						(C) <u>Re Hemiplegia</u> <u>1 yr.</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>11/14</u> <u>19 69</u> to <u>11/30</u> <u>19 69</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>11/24</u> <u>19 69</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above. (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.									
23A. SIGNATURE <u>Kenneth Smoleritz</u>						23B. DATE SIGNED <u>12/2/69</u>			
23C. PHYSICIAN'S NAME (Type) <u>Dr. E. E. Fisher, M.D.</u>						23D. ADDRESS <u>G. Truman Schwab</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Dec. 3, 1969</u>		24C. NAME of CEMETERY or CREMATORY <u>Balto. National Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1969</u>		25B. NAME OF REGISTRAR <u>G. Truman Schwab</u>		25C. FUNERAL DIRECTOR <u>21229</u>		ADDRESS <u>3512 Frederick Ave. Balto.</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452		69 12015		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12015	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Bessie Williams				2. DATE AND HOUR OF DEATH December 3, 1969 7:10 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital, Inc.				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 5300			
				C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER 7923 Oakdale Ave. #37			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/10/85	9. AGE (In years last birthday) 84	10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Edward Fitzgerald			
14. MOTHER'S MAIDEN NAME Vira Myers				15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 209368262				17. INFORMANT Marlette Fry ADDRESS 7923 OAKDALE AVE.			
18. CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF:			
				(B) Refractory asphyxia DUE TO, OR AS A CONSEQUENCE OF: progressive			
				(C) Terminal extensive Cor of Cecum 5 months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 7/11/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cancer of Bowel		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 11/30 19 69 to 12/3 19 69 that (1) (we) last saw the deceased alive on 12/3 19 69 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. C. L. ARM				23B. DATE SIGNED 12/3/69		23C. PHYSICIAN'S NAME (Type) H. C. L. ARM	
23D. ADDRESS MERCY HOSPITAL				23E. NAME OF REGISTRAR Philip E. Czech		23F. FUNERAL DIRECTOR 1211 Chesaco Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-7-69		24C. NAME OF CEMETERY or CREMATORY St. Lukes United Cemetery		24D. LOCATION (City, town, or county) (State) Dunnstown, Pennsylvania	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR Philip E. Czech		25C. FUNERAL DIRECTOR 1211 Chesaco Ave.		ADDRESS	



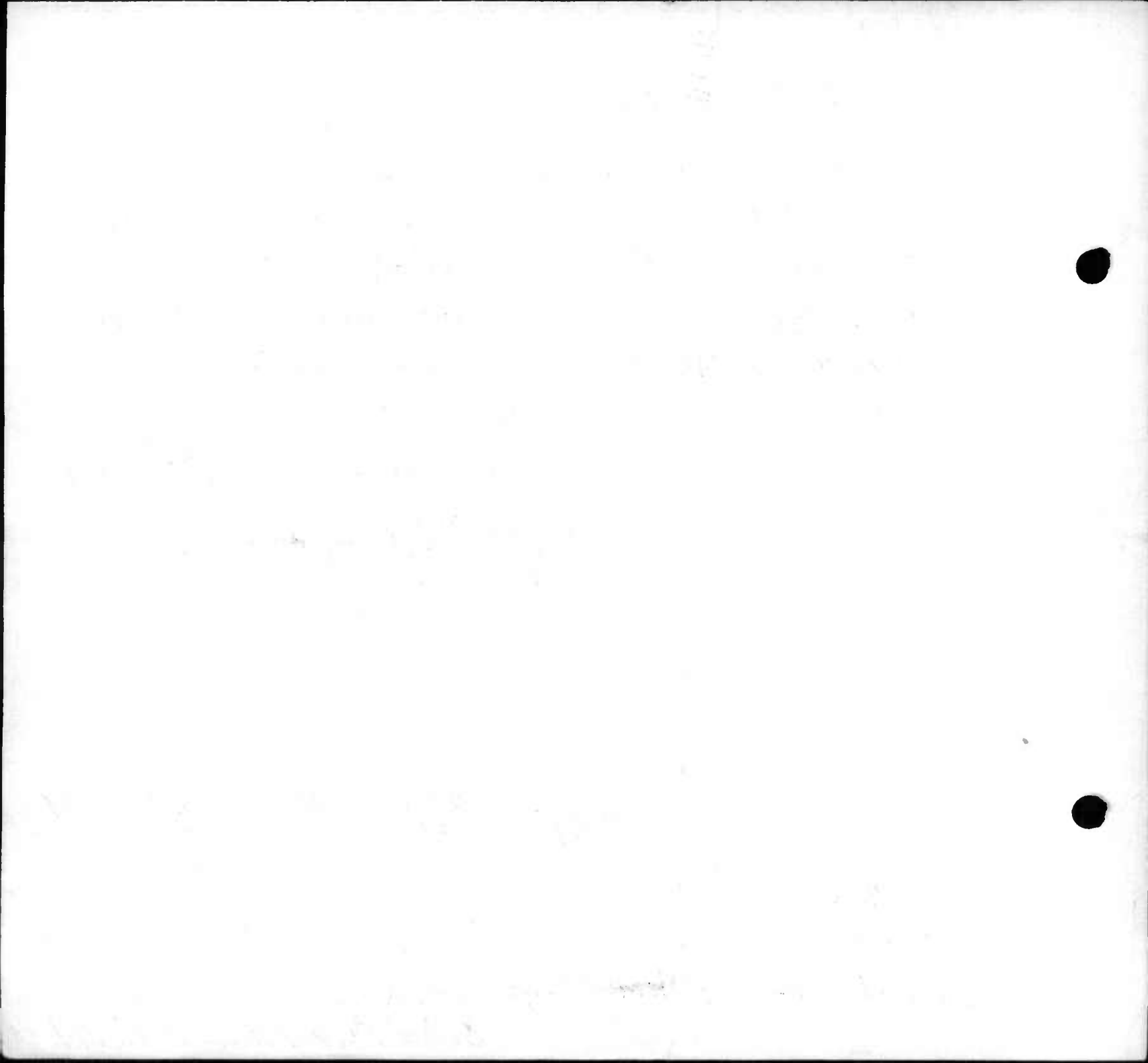
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-200		69 12016		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12016	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) HAYES, RALPH JOSEPH RALPH			
2. DATE AND HOUR OF DEATH DECEMBER 4, 1969 10:50A.M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2553 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2024 HARMAN AVE 21230			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 08/15/11	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY KOPPERS CO		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W. CHARLES HAYES				14. MOTHER'S MAIDEN NAME THERESA KKXKX (NEE HINES) HAYES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE		16. SOCIAL SECURITY NO. 216-03-0090		17. INFORMANT Lillian M. Hayes 2024 Harman Ave. 21230 ST. AGNES HOSPITAL RECORDS		ADDRESS	
18. <u>147X1</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>tracheo bronchitis</u>				(A) IMMEDIATE CAUSE <u>metastatic neoplastic disease</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>nasopharyngeal carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>	
19A. DATE OF OPERATION <u>none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>DECEMBER 2</u> 19 <u>69</u> to <u>DECEMBER 4</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>DECEMBER 4</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>George S. Patrick M.D.</u>				23B. DATE SIGNED <u>12-4-69</u>			
23C. PHYSICIAN'S NAME (Type) G PATRICK, M.D.				23D. ADDRESS BALTIMORE, MARYLAND 21229 ST. AGNES HOSP; CATON & WILKENS AVES			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-69		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR <u>Howard H. Hubbard</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>		ADDRESS 21229 4107 Wilkens Ave	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-320		69 12017		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12017	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) MAY E FITCH				2. DATE AND HOUR OF DEATH 12 11 69 4:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSP BALTO. MD				4. USUAL RESIDENCE (Where deceased lived if institution; residence below admission) A. STATE MD B. COUNTY 1348			
				C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3660 BUENA VISTA AVE.			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/8/04		9. AGE (In years last birthday) 65 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES LINDSEY				14. MOTHER'S MAIDEN NAME MAGGIE LEE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217 059723		17. INFORMANT CHART ADDRESS			
18. CAUSE OF DEATH 23019 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 8 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				(A) IMMEDIATE CAUSE MASSIVE BLEED PER RETINAL FISSURE 24hr DUE TO, OR AS A CONSEQUENCE OF: X10yrs. DIABETES, CHF, PERIPHERAL VASC INSG. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 10/11/1969 to 10/11/1969 and that (I) (we) last saw the deceased alive on 10/11/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harvey B. Sher MD DEGREE 23B. DATE SIGNED				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
23C. PHYSICIAN'S NAME (Type) HARVEY B. SHER MD DEGREE				23D. ADDRESS UNION MEMORIAL HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-4-69		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Mem PK		24D. LOCATION (City, town, or county) (State) Howard Co Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR Burgess Funeral Home Balto Md		ADDRESS	



D-325

69 12018

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12018

BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOSEPH MANUEL DODSON Joseph Dobson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year Hour		M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 21 S. Collington Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 30 69 11:20 a.m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 105		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 3-26-1919		10. AGE (In years lost birthday) 50 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME RUFUS MANUEL DODSON		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAB DRIVER		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W.W.II		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME GRACE TANNER		18. INFORMANT MARY B. DODSON		ADDRESS 14 S. COLLINGTON AVE.	
19. 1619 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Carcinoma of larynx DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner		DATE SIGNED 12/1/69		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	
24B. DATE 12-3-1969		24C. NAME of CEMETERY or CREMATORY NOVUM CEMETERY		24D. LOCATION (City, town, or county) (State) NOVUM VIRGINIA		25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR Werner U. Spitz	
25C. FUNERAL DIRECTOR Werner U. Spitz		ADDRESS 2101 Frederick Ave							

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JAN 22 1912

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MEMPHIS

THE LITTON

LOS ANGELES

WILLIAM WATSON

GRACE TAYLOR

MARY E. TAYLOR 14 E. COLLETON ST.

WILLIAM WATSON & CO.

WILLIAM WATSON

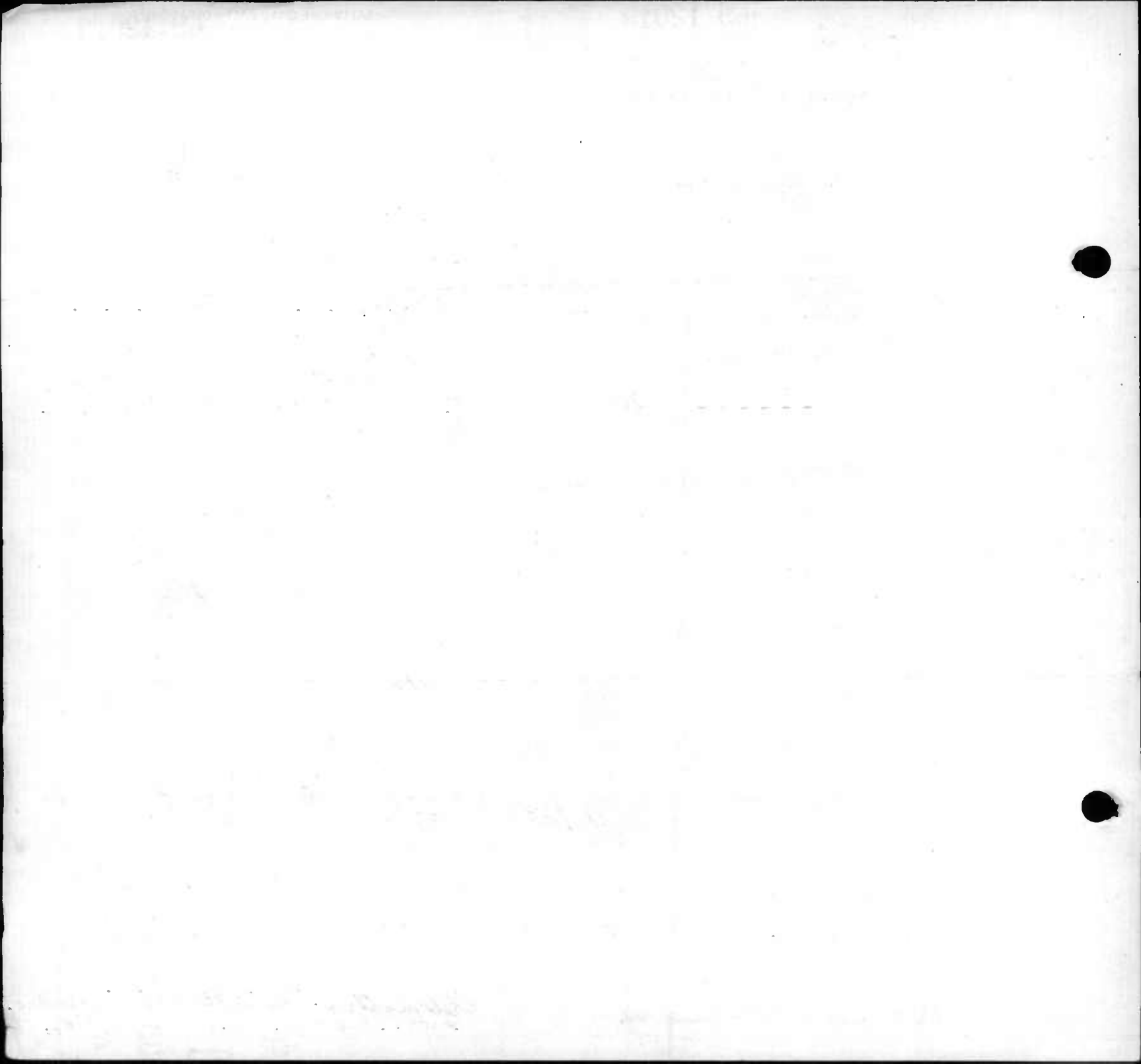
WILLIAM WATSON

WILLIAM WATSON

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-250		69 12019		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12019	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lawrence ELIZABETH McQUEEN</i>				2. DATE AND HOUR OF DEATH <i>12/2/69 5¹⁰ P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Lake Drive Nursing Home</i>						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Montgomery</i> C. CITY OR TOWN <i>Forest Glen</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>Caney Place</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 24, 1892</i>		9. AGE (In years last birthday) <i>77</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Receptionist</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Photography</i>		11. BIRTHPLACE (State or foreign country) <i>Washington, D. C.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Boyd Mc Queen</i>				14. MOTHER'S MAIDEN NAME <i>Jennie Russell</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>YES</i>		17. INFORMANT <i>Sister</i> <i>Mrs. Hugh Buckingham, 9407 Hale Place Silver Spring, Md.</i>			
18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Acute Myocardial Infarction</i> <i>ASCVD</i>						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>12/27</i> 19 <i>68</i> to <i>12/2</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>11/28</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>W. Allen</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/2/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>MARCELIN F. MURDERE MD</i>				23D. ADDRESS <i>7935 PIPER PATH Glen BURNIE MD 2106</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/4/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Rock Creek Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Washington, D. C.</i>			
25A. DATE RECEIVED BY HEALTH DEPT. <i>DEC 5 1969</i>				25B. NAME OF REGISTRAR <i>W. Allen</i>		25C. FUNERAL DIRECTOR <i>C. Glen Carter 8434 Georgia Ave. Silver Spring, Md.</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

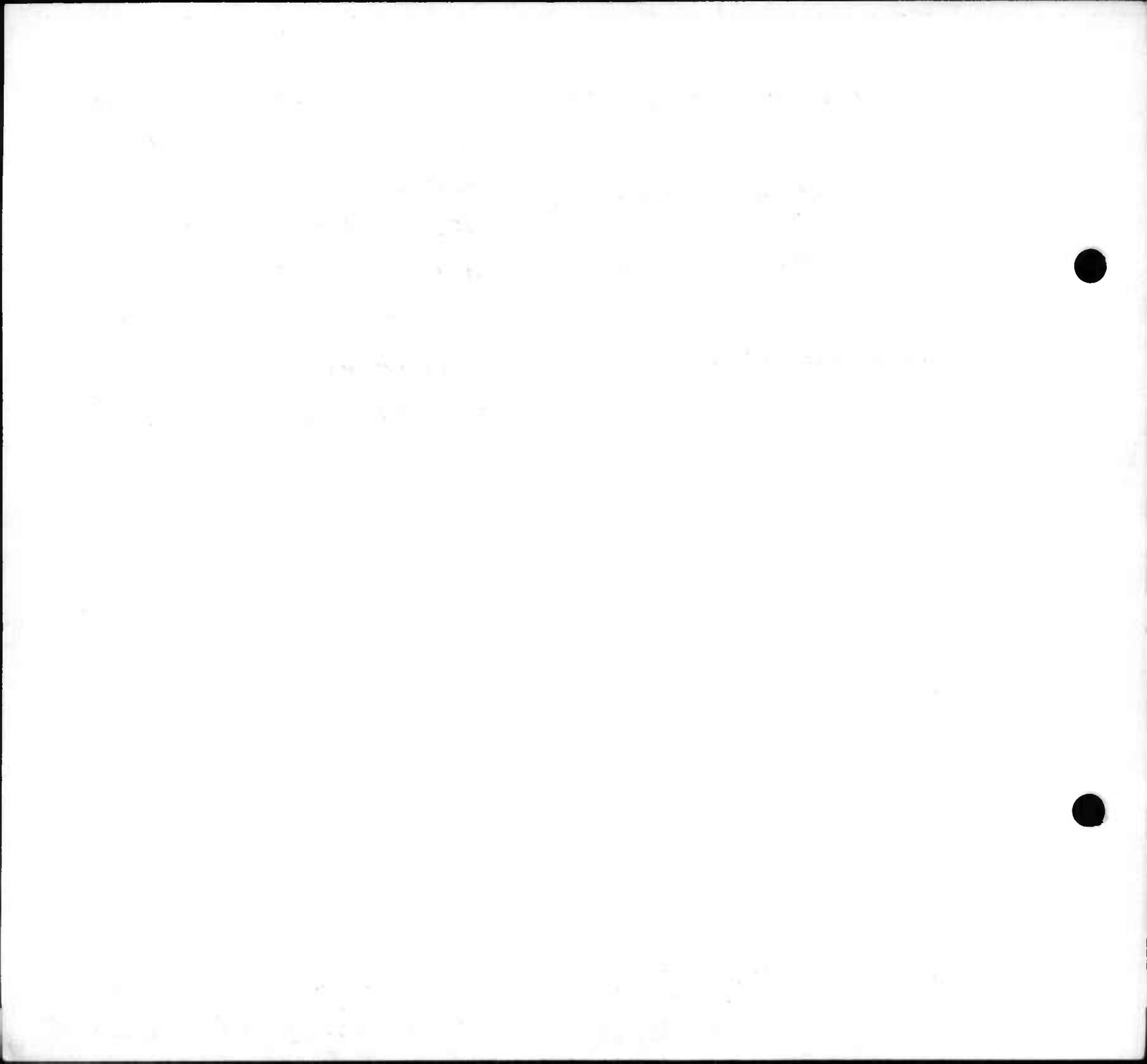
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12020</u>	
B-520		69 12020		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>BUNCH JOSEPH</u>		2. DATE AND HOUR OF DEATH <u>11/22/69</u> <u>3-15</u> <u>A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2802</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>46 Lutheran Hospital of MD</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M.</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>3-18-94</u>		9. AGE (in years last birthday) <u>75</u> yr	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Bunch</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Barker</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Leanda Bunch 2280 Brighton</u>		ADDRESS	
18. <u>792X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Uraemia</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Uraemia</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-10-</u> 19 <u>69</u> to <u>11-22-</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>11-22-</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>KANTILAL J SHAH MD</u>				23B. DATE SIGNED <u>11/22/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Kantilal J Shah MD</u>				23D. ADDRESS <u>Lutheran Hospital of MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>11/25/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mount Calvary Luth A & Co. Inc</u>	
24D. LOCATION (City, town, or county) (State) <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1969</u>		25B. NAME OF REGISTRAR <u>John E. Kelly</u>	
25C. FUNERAL DIRECTOR <u>John E. Kelly</u>		25D. ADDRESS <u>106 W. W. Montgomery</u>			

Address is 3218th Brighton ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12021		REG. NO. 69 12021	
T-512				69 12021		69 12021	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) ANDREW W Thompson, JR		2. DATE AND HOUR OF DEATH 12/4/69 8:AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1803			
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University of Maryland Hospital				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE NEGRO 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 3-1-27 9. AGE (in years last birthday) 42		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Mississippi	
13. FATHER'S NAME ANDREW THOMPSON SR				14. MOTHER'S MAIDEN NAME EDNA ANDERSON		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II				16. SOCIAL SECURITY NO. 427-42-5284		17. INFORMANT Mary Thomas 164 Clinton Ave, Albany, N.Y.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) Hemo-Renal Syndrome DUE TO, OR AS A CONSEQUENCE OF: (C) Bleeding Gastric Ulcer		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 1 wk 13 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 3/1/73		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Gastric Ulcer		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/23 19 68 to 12/4 19 69 that (I) (we) last saw the deceased alive on 12/4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Lloyd B. Manuel MD				23B. DATE SIGNED 12/4/69		23C. PHYSICIAN'S NAME (Type) Lloyd B. Manuel	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/9/69		24C. NAME OF CEMETERY OR CREMATORY GRACELAND	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969				25B. NAME OF REGISTRAR Charles A. Rice		25C. FUNERAL DIRECTOR'S ADDRESS 661 W. Barre St.	



W-300

69 12022 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12022

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Albert Wade		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1915 E. Fairmount Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 2 69 11:25 a.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 604			
6. SEX male	7. RACE colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 3-8-03		10. AGE (In years last birthday) 66	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Laura Howell		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 218-09-8295		18. INFORMANT ADDRESS Mrs. Henrietta Wade 1915 E. Fairmount Ave.	
19. 4124 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/2/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-6-69	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR W. E. Taylor	
25C. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS 3035 W. North Ave.	

SSUSJ 04

1400 03 27

1993 03 27 1400 03 27

ACADEMY OF MUSIC

CONCERT

WINTER PAVILION

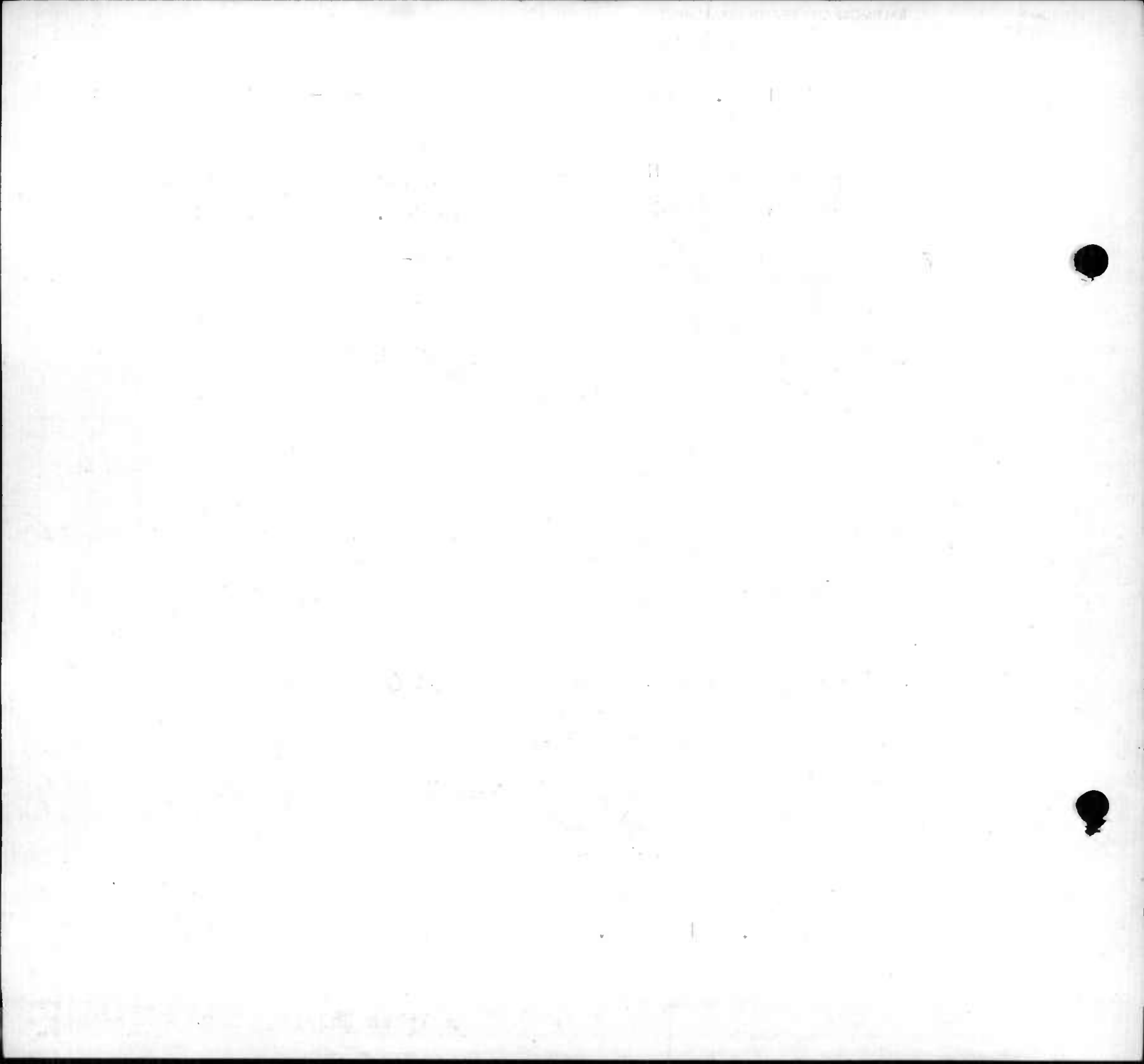
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12023
<div style="font-size: 1.5em; font-weight: bold;">M-620</div> <div style="font-size: 1.2em; font-weight: bold;">69 12023</div>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
LILLIE M. MARSH		11-30-69 12:15 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE JOHNS HOPKINS HOSPITAL 33 BALTIMORE, MD 21205		A. STATE MARYLAND		
		B. COUNTY		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		1033 N. CHAPEL STREET		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
FEMALE	NEGRO		04-10-23	46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
HOUSEWIFE				NORTH CAROLINA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
JOE RAKESTRAW		ETHEL FOSTER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
		577-42-6589		Chart
18. 1830 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		24 hrs.
		(B) Ovarian Carcinoma		6 months
		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
Nov 14, 1969		Ovarian Ca		No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from Nov 6 19 69 to Nov 30 19 69 , that (I) (we) last saw the deceased alive on Nov 30 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Duncan R. Neilson, Jr. M.D.				Nov 30, 1969
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
DUNCAN R. NEILSON M.D.		JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial	12/6/69	Mt. Auburn Cemetery		Baltimore MD
25A. DATE RECEIVED BY HEALTH DEPARTMENT		25C. FUNERAL DIRECTOR		ADDRESS
DEC 5 1969		John E. J. [unclear]		440 Ohio St. Balstead 1206 W North Ave



4-252 1

BALTIMORE CITY HEALTH DEPARTMENT

69 12024

CERTIFICATE OF DEATH

REG. NO.

69 12024

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PEARL HASKINS

2. DATE AND HOUR OF DEATH

12/3/69

5:45 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MD.

1204

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2218 N. Calvert St.

5. SEX

F

6. RACE

C

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

10/10/17

9. AGE (In years
last birthday)

52

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

George Hudson

14. MOTHER'S MAIDEN NAME

ROSE

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Willard Haskins 2218 Calvert St.

18. 574.91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC arrest

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Septic shock

(C)

Cholangitis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

10/8 - 10/20/69

19B. CONDITION FOR WHICH OPERATION

WAS PERFORMED

Cholecholelithiasis & cholangitis

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10/8/69 19 69 to 12/3 19 69,
that (I) (we) lost saw the deceased alive on 12/3 19 69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

[Signature]

M.D.

OEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/3/69

23C. PHYSICIAN'S
NAME (Type)

CARLOS E. Fossi

M.D.

OEGREE

23D. ADDRESS

UNION MEMORIAL Hospital

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

12/8/69

24C. NAME OF CEMETERY or CREMATORY

Mt. Calvary Cem.

24D. LOCATION

(City, town, or county)

(State)

Anne Arundel Cty. Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 5 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

25C. FUNERAL DIRECTOR

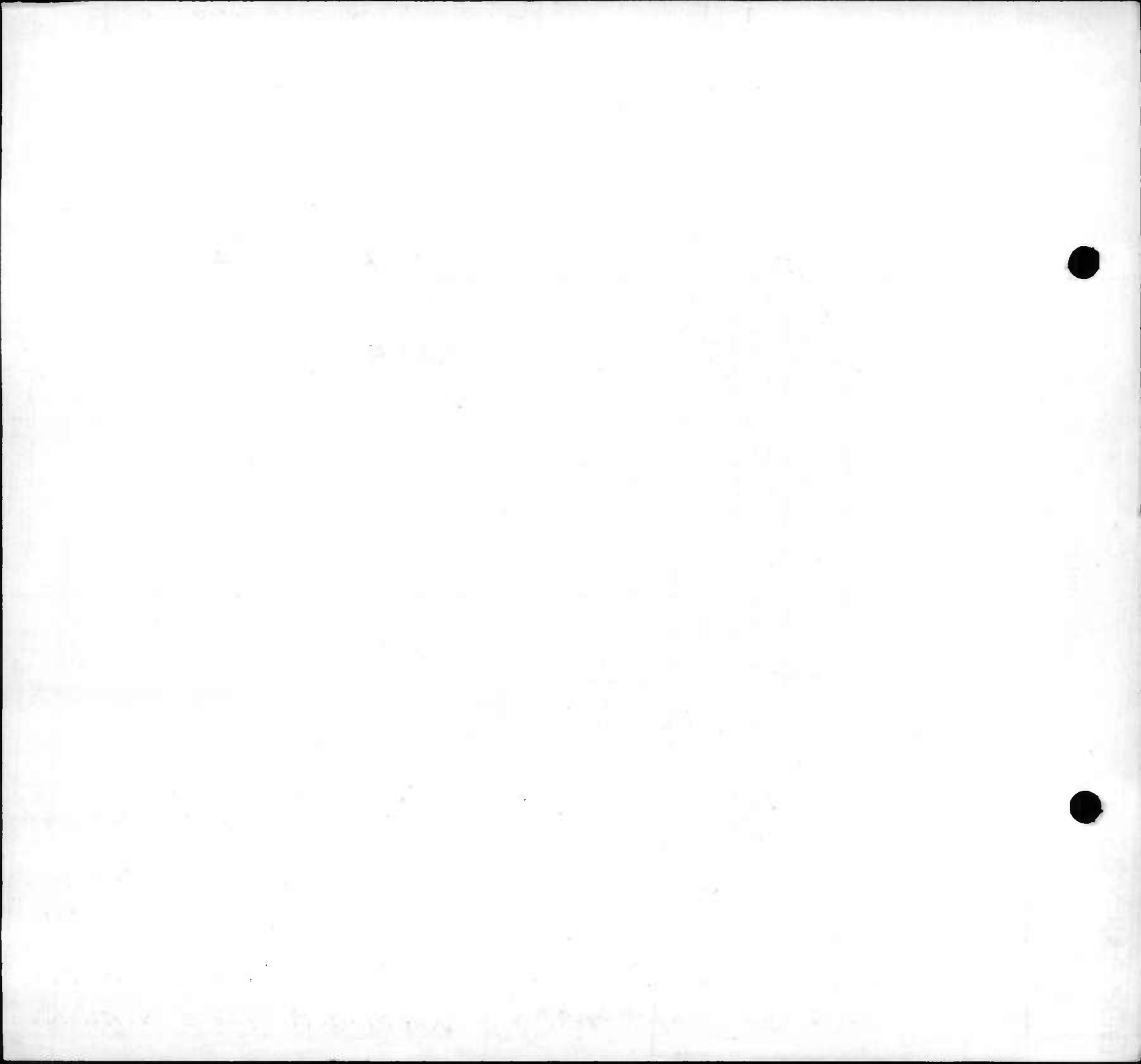
Wm. March

ADDRESS

928 E North Ave

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



G-630

69 12025 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12025

BIRTH NO.		1. NAME OF DECEASED (Type or Print) SOLOMAN GARRETT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month November Day 27 Year 1969 Hour M. Estimated <input type="checkbox"/>	
46 99		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Full name of hospital or institution (If not in hospital or institution, give street address or location) Lutheran Hospital (DOA)		3. DATE PRONOUNCED DEAD Month November Day 27 Year 1969 Hour 3:10 P. M.	
6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Spined 1900 Unknown		10. AGE (In years last birthday) 69		11. BIRTHPLACE (State or foreign country) Texas Unknown	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown	
15. MOTHER'S MAIDEN NAME Unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214343347	
18. INFORMANT Mrs. Carrie Lopez		ADDRESS 2309 Roslyn Ave.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. 486 X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED November 28, 1969					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/69		24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cem. Brooklyn	
24D. LOCATION (City, town, or county) (State) Mt. Calvary Cem. Brooklyn		25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR John E. Kelly	
25C. FUNERAL DIRECTOR Joseph L. Russ		ADDRESS 2222 W. North Ave.			

K-242 1

69 12026

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 12026

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

John J. Kozlowski

2. DATE AND HOUR OF DEATH

12/2/69

7:00

A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)University of Maryland Hospital
38

4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)

A. STATE

Md.

B. COUNTY

1803

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

812 Hollins St

5. SEX

Male

6. RACE

Cauc

7. MARRIED

☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

1/9/05

9. AGE (In years
last birthday)

64

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Cashier Clerk

10B. KIND OF BUSINESS OR INDUSTRY

Courier Service

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Kozlowski

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

Yes

(If yes, give war or dates of service)

2 Jan 43 thru 24 Aug 45

16. SOCIAL
SECURITY NO.

213-09-7308

17. INFORMANT

Ann Kozlowski 1449 Towson St,

ADDRESS

1B.

14591

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Pneumonia

Squamous cell

(B)

Carcinoma - Mouth - inoperable

DUE TO, OR AS A CONSEQUENCE OF:

(C)

Falls from a construction site

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 days

6 months

UNKNOWN

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Malnutrition, alcoholism

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

22. I certify that (I) (this hospital) attended the deceased from 11/20 19 67 to 12/2 19 67
that (I) (we) last saw the deceased alive on 12/2 19 67 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Lloyd B. Mandel MD

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

Lloyd B. Mandel

DEGREE

23D. ADDRESS

Univ. of Md. Hosp.

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

1/8/69

24C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 5 1969

25B. NAME OF REGISTRAR

Dr. E. T. Talley, MD

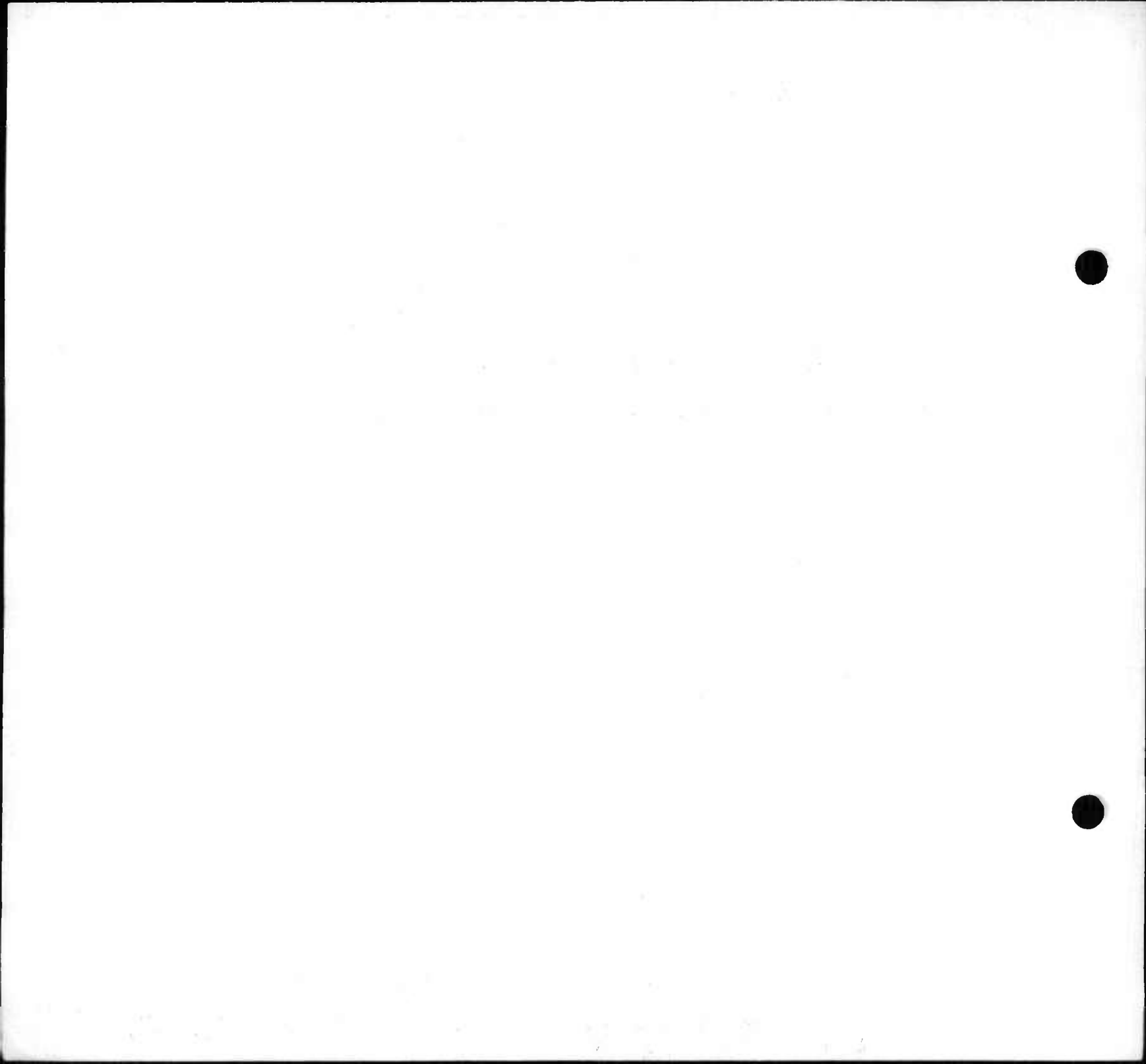
25C. FUNERAL DIRECTOR

L. J. Ferrells Funeral Home, Inc.
1501 East Fort Avenue

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

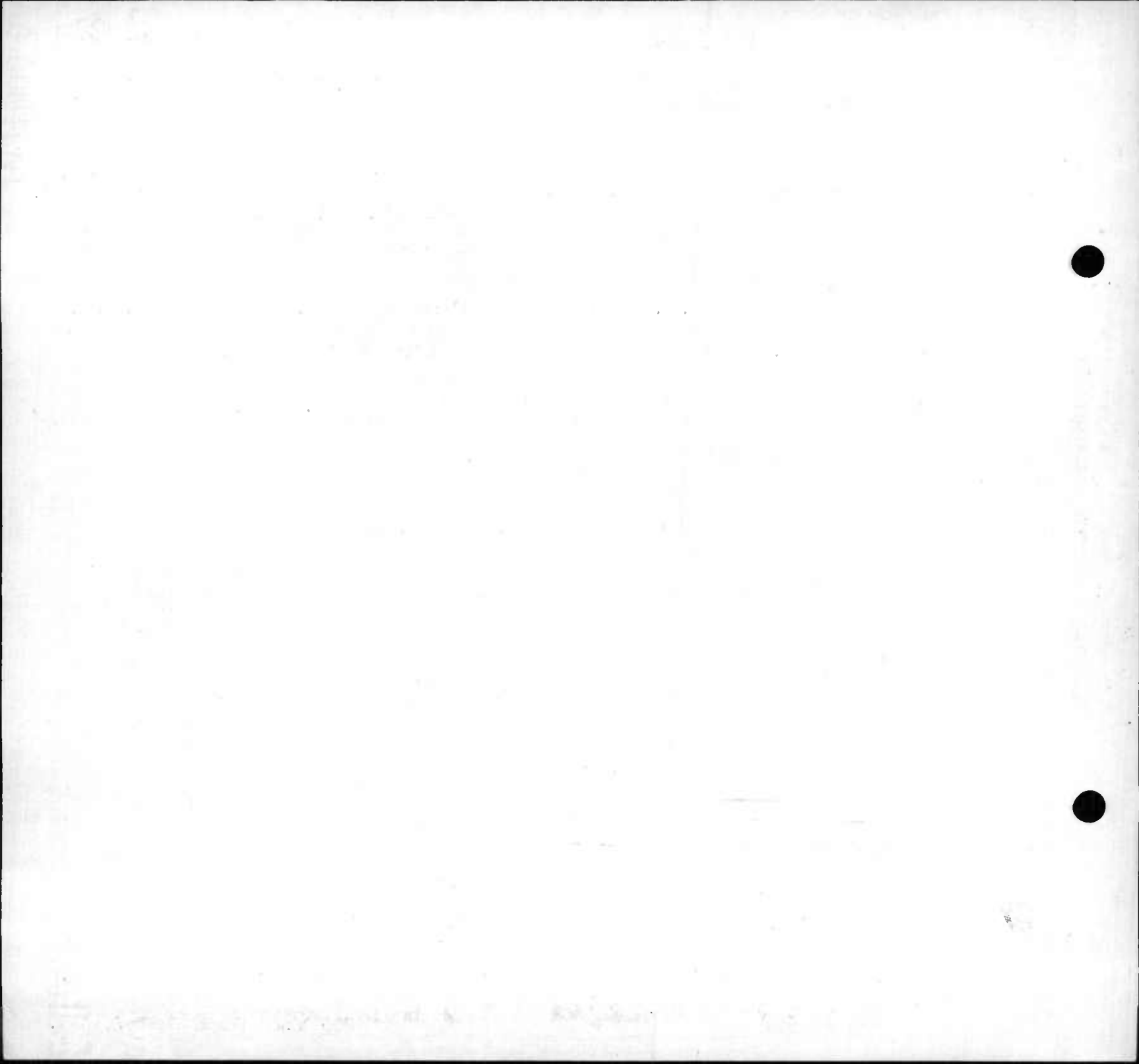
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12027

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 12027

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Herbert Keith Clayton		Dec. 1, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
90 Pleasant Manor Nursing Home				Maryland	
				C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 922 W. University Parkway	
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-4-1915	9. AGE (In years last birthday) 54
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Postal Clerk		U.S. Post Office		Baltimore, Md.	
13. FATHER'S NAME Clarence H. Clayton				14. MOTHER'S MAIDEN NAME Lillian Belle Cooksey	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes WWII		220-09-8979		Miss Helen W. Clayton	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Cerebrovascular accident</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>8-8</i> 1969 to <i>11-30</i> 1969, that (I) (we) last saw the deceased alive on <i>11-25</i> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE <i>Frank G. Kuehn</i>				23B. DATE SIGNED <i>12-1-69</i>	
23C. PHYSICIAN'S NAME (Type) Dr. Frank G. Kuehn				23D. ADDRESS Medical Arts Building <i>721</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-3-1969		24C. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 5 1969</i>		25B. NAME OF REGISTRAR <i>John E. Jenkins</i>		25C. FUNERAL DIRECTOR <i>Henry W. Jenkins & Sons Co.</i>	
				ADDRESS 4905 York Road Balto., Md.	



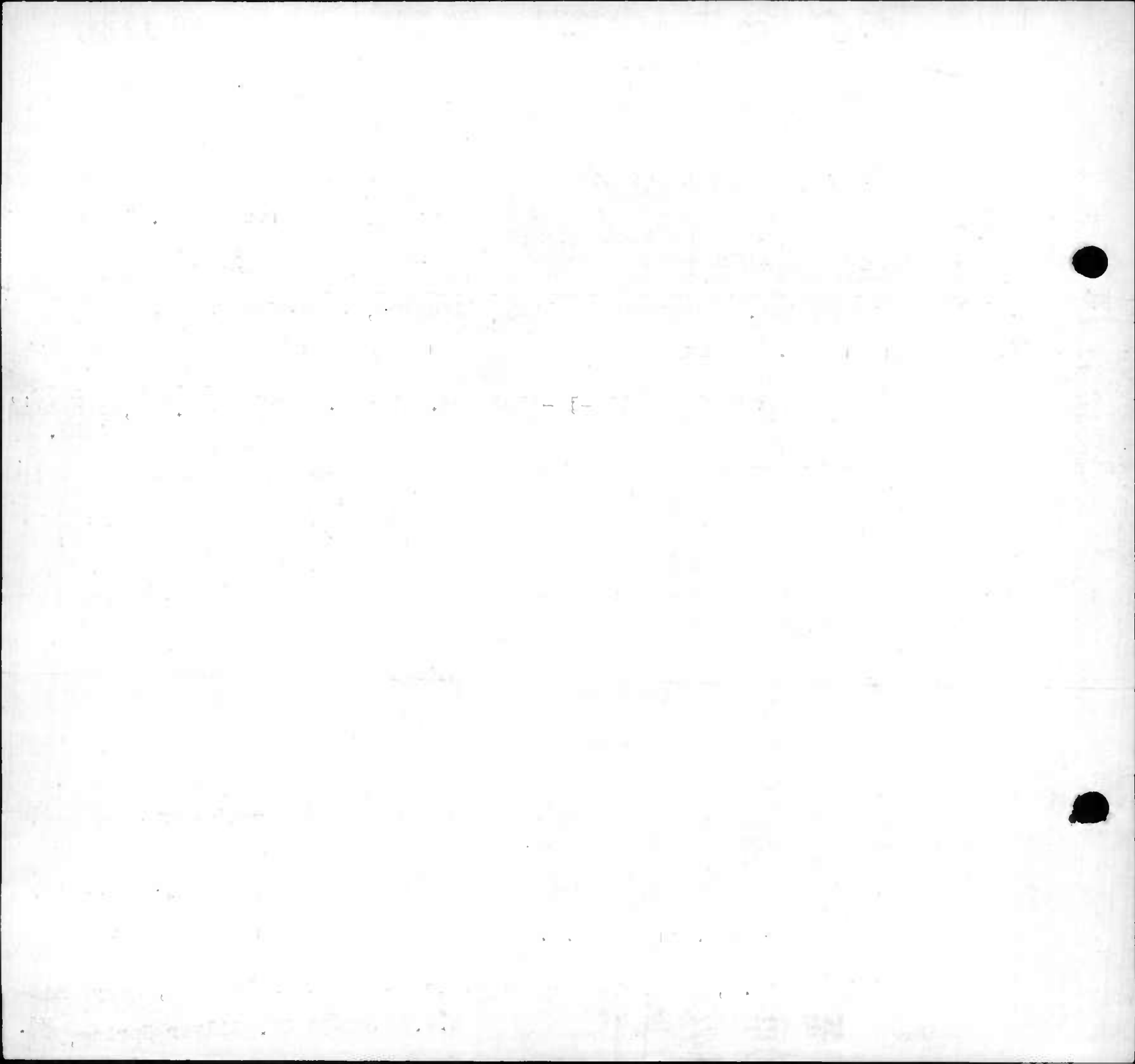
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-450		69 12028		BALTIMORE CITY HEALTH DEPARTMENT		69 12028	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>ELLEN, OBIE</u>				2. DATE AND HOUR OF DEATH <u>2:20 pm. 12-3-69</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MARYLAND</u>		B. COUNTY <u>27 16</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>463 Park Heights Ave.</u>		F. INSIDE CITY LIMITS? <u>MT SINAI Nursing Home</u>	
5. SEX <u>MALE</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-18-96</u>	9. AGE (In years last birthday) <u>73</u>	10. UNDER 1 Yr. Months: Days: Hours: Min.	11. UNDER 24 Hrs. Hours: Min.	12. CITIZEN OF WHAT COUNTRY?
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Operator</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Ford Machinery Co.</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Charlie Allen</u>				14. MOTHER'S MAIDEN NAME <u>Ella Lunsford</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes W. W. #1</u>				16. SOCIAL SECURITY NO. <u>213-01-9483</u>		17. INFORMANT <u>Mrs Anna Tucker</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>185X I</u>				CAUSE OF DEATH <u>congestive heart failure</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10:20 pm 12-2-69</u>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>La Prostate with metastases</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>2:20 pm 12-3-69</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-2-69</u> to <u>12-3-69</u> , that (I) (we) last saw the deceased alive on <u>12-3-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>P. G. Naneswaran</u>						23B. DATE SIGNED <u>12-3-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>P. G. NANESWARAN</u>				23D. ADDRESS <u>Lutheran Hospital</u> <u>ASHBURN ST. BALTIMORE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-8-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>National Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1969</u>		25B. NAME OF REGISTRAR <u>Callie F. H.</u>		25C. FUNERAL DIRECTOR <u>2431 E. Oliver St.</u>		ADDRESS	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

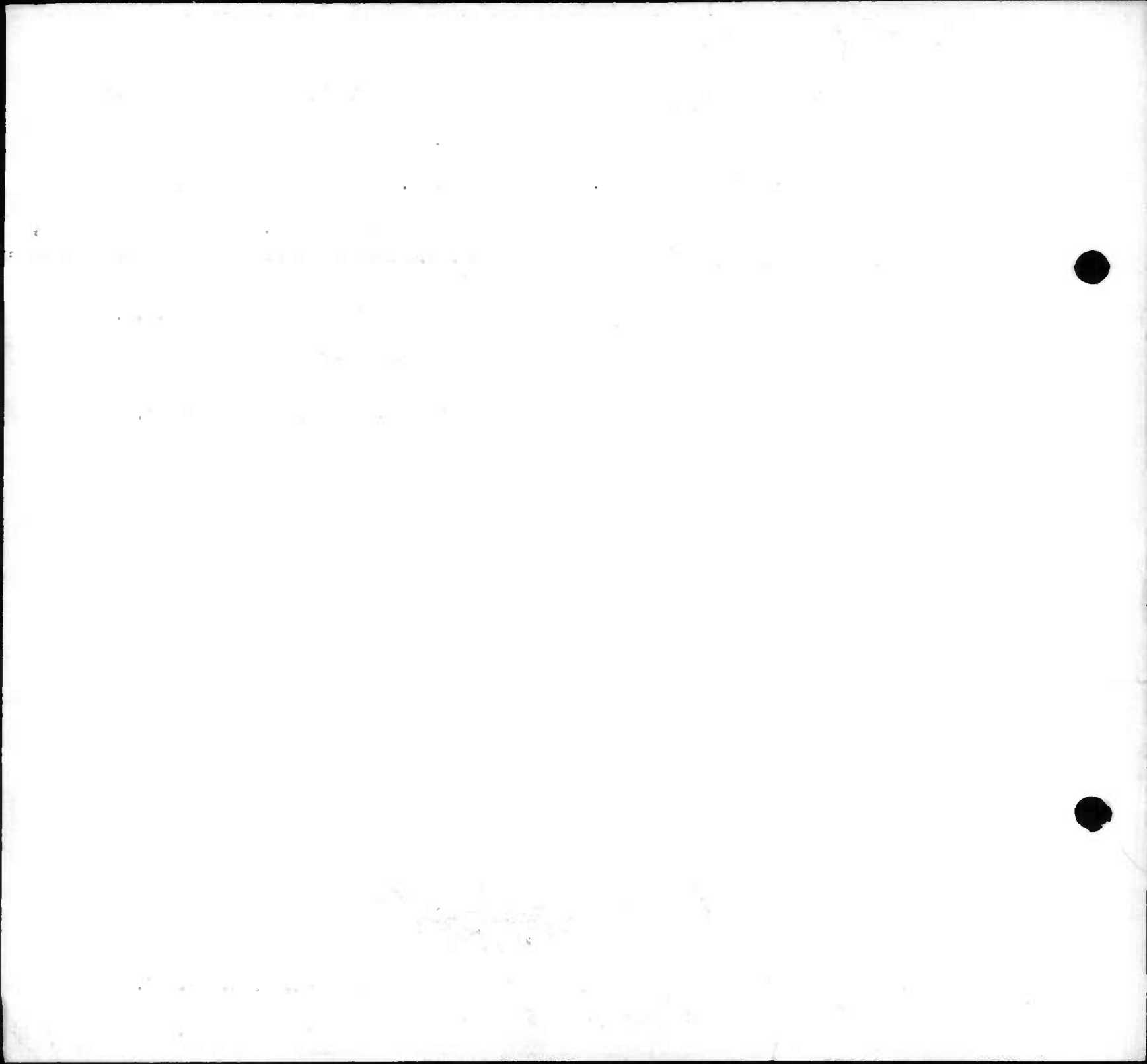
L-340 69 12029		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12029	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES, Melvin LITTLE		2. DATE AND HOUR OF DEATH 12/2/69 3:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNAPOLIS		C. CITY OR TOWN ANNAPOLIS		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 33 Johna Hopkins Hospital		ADDRESS OR LOCATION		E. STREET AND NUMBER 1015 NORMAN DRIVE		Apt. 102	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-23-97	9. AGE (In years last birthday) 72	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney Ret.		10B. KIND OF BUSINESS OR INDUSTRY Southern Railway		11. BIRTHPLACE (State or foreign country) Pitcairn, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM G. LITTLE		14. MOTHER'S MAIDEN NAME ALICE CAMERON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 718-10-5762		17. INFORMANT Mrs. Ella P. Little		ADDRESS 1015 Norman Dr. Apt. 102, Annapolis, Md.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3.45 PM			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2 PM 12/2 1969 to 3:45 PM 1969 , that (I) (we) last saw the deceased alive on 12/2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James E. Miller MD		23B. DATE SIGNED 12/2/69		23C. PHYSICIAN'S NAME (Type) JAMES E. MILLER M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 5, 1969		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR W.W. CHAMBERS CO.		25C. FUNERAL DIRECTOR W.W. CHAMBERS CO.		ADDRESS Silver Spring, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-654 69-72363 69 12030 BALTIMORE CITY HEALTH DEPARTMENT </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. 69 12030	
BIRTH NO. 69-72363 1. NAME OF DECEASED (Type or Print) <u>Baby Girl Crumley</u>		2. DATE AND HOUR OF DEATH <u>12/3/69</u> <u>9:30</u> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37</u> <u>Mercy Hospital, Inc.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>903</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>637 McKewin Ave.</u>	
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/28/69</u>
9. AGE (In years last birthday) <u>5 Days</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Hubert Crumley</u>		14. MOTHER'S MAIDEN NAME <u>Donna Woodie</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <u>Hubert Crumley 637 Kc Kewin Ave.</u>
18. <u>486X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>Cardio-respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>premature perinatal</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>aspirator pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 28</u> 19 <u>69</u> to <u>Dec. 3</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Dec. 4, 1969 9:40 PM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Bai-Fan Chen</u>		23B. DATE SIGNED <u>Dec. 4, 69</u>	
23C. PHYSICIAN'S NAME (Type) <u>Bai-Fan Chen M.D.</u>		23D. ADDRESS <u>Mercy Hospital</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12 5 69</u>	24C. NAME of CEMETERY or CREMATORY <u>Holy Cross</u>	24D. LOCATION (City, town, or county) (State) <u>Brooklyn, A. A. Co. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 5 1969</u>		25B. NAME OF REGISTRAR <u>Mc Cully</u>	
25C. FUNERAL DIRECTOR <u>130 E. Port Ave</u>		ADDRESS	



1

H-124 69 12031

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12031

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JULIUS HIPSLEY HIPSLEY

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

December

3

1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

CITY HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

December 3, 1969

10:05 A.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

BALTO 5300

6. SEX

Male

7. RACE

White

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Essex

D. INSIDE CITY LIMITS?

YES ☐NO ☒

9. DATE OF BIRTH

AUG. 27, 1923

10. AGE (In years
last birthday)

46

11. Under 1 Yr. 12 Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

Rt. 14, Box 607-A

11. BIRTHPLACE (State or foreign country)

M.D.

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

HERBERT HIPSLEY

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

BLOG.

15. MOTHER'S MAIDEN NAME

EMMA YAKEL

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW II

17. SOCIAL
SECURITY NO.

212-20-8360

18. INFORMANT

ERMA HIPSLEY

ADDRESS

ABOVE

19.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

Arteriosclerotic Cardiovascular Disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)22E. INJURY OCCURRED
WHILE AT ☐ NOT WHILE
WORK AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/3/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12/6/69

24C. NAME OF CEMETERY or CREMATORY

GARDENS OF FAITH

24D. LOCATION (City, town, or county)

BALTO.

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

DEC 5 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

J. O. CHANLEY, 5045

ADDRESS

300 MACE

NAME: [illegible]
DATE: [illegible]

TEST NUMBER: [illegible]

HERBERT H. [illegible]
[illegible]

NAME: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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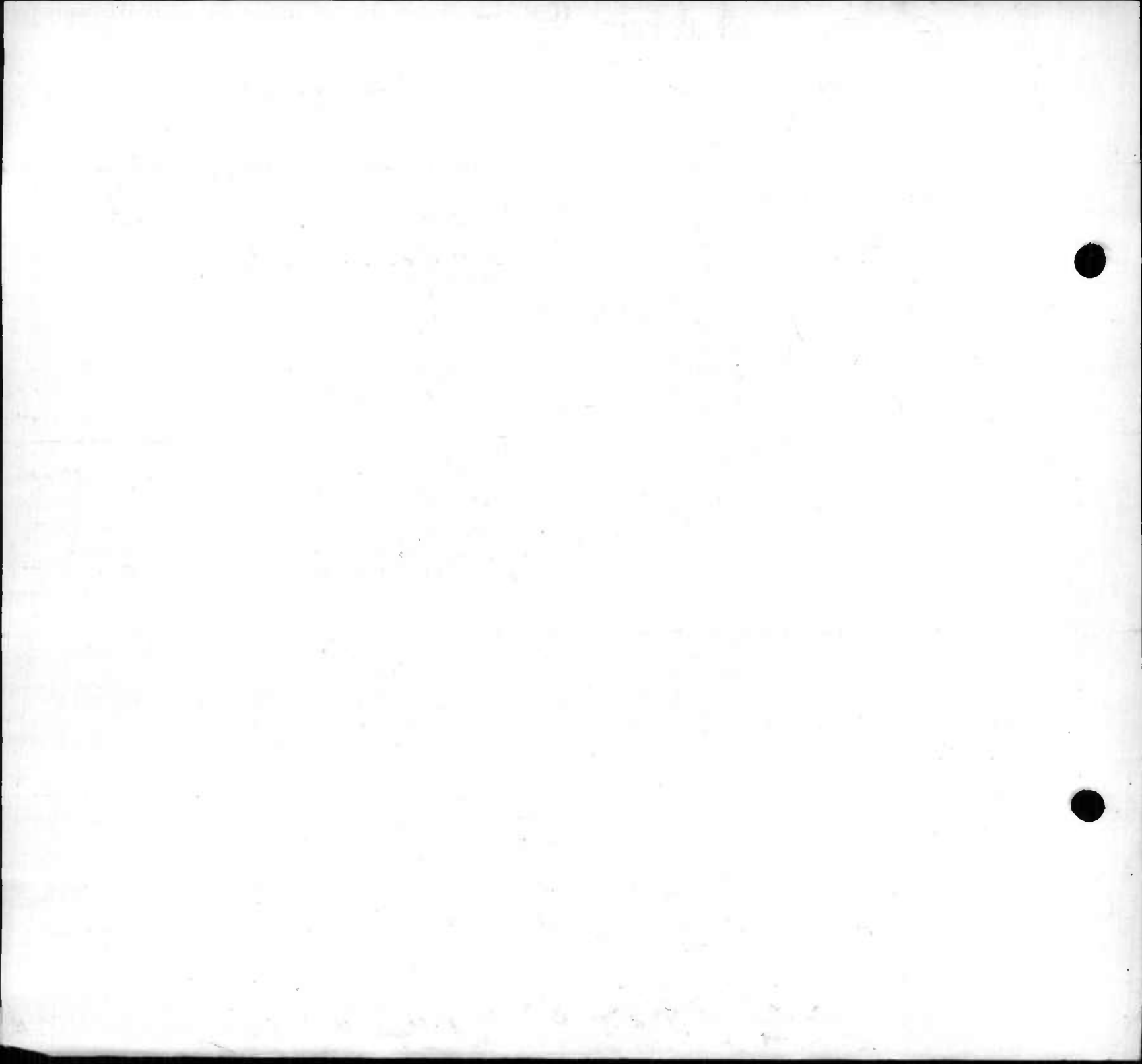
[illegible]

[illegible]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> G-656 69 12032 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> Guerrini CERTIFICATE OF DEATH REG. NO. 69 12032 </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mabel Guerrini</i>		2. DATE AND HOUR OF DEATH <i>2 Dec 69</i> <i>350 P</i> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2735</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>South Balto. Gen'l Hosp. & Tu</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9 Dec 46</i>	9. AGE (In years lost birthday) <i>22</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Prosthetics</i>		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	
13. FATHER'S NAME <i>Darlington C. Hoar</i>		14. MOTHER'S MAIDEN NAME <i>Unkown</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>U</i>		16. SOCIAL SECURITY NO. <i>193-36-0018</i>		17. INFORMANT <i>Hospital sheet</i> ADDRESS	
18. <i>1925</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pulmonary effusion</i>		<i>2 days</i>	
		(B) <i>metastases</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>1 m or</i>	
		(C) <i>neuroleptic</i>		<i>6 months</i>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1 Dec</i> 19 <i>68</i> to <i>2 Dec</i> 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>2 Dec</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Th. H. Powell</i> DEGREE				23B. DATE SIGNED <i>2 Dec 69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Th. H. Powell</i> DEGREE				23D. ADDRESS <i>2 E. Reed St. 21202</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/5/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Moreland Memorial Park</i>	
24D. LOCATION (City, town, or county) <i>Balto, Maryland</i>		24E. NAME OF REGISTRAR <i>Th. H. Powell</i>		25. FUNERAL DIRECTOR <i>Th. H. Powell</i> ADDRESS <i>7401 Bel Air Rd</i>	



M-352

69 12033 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12033

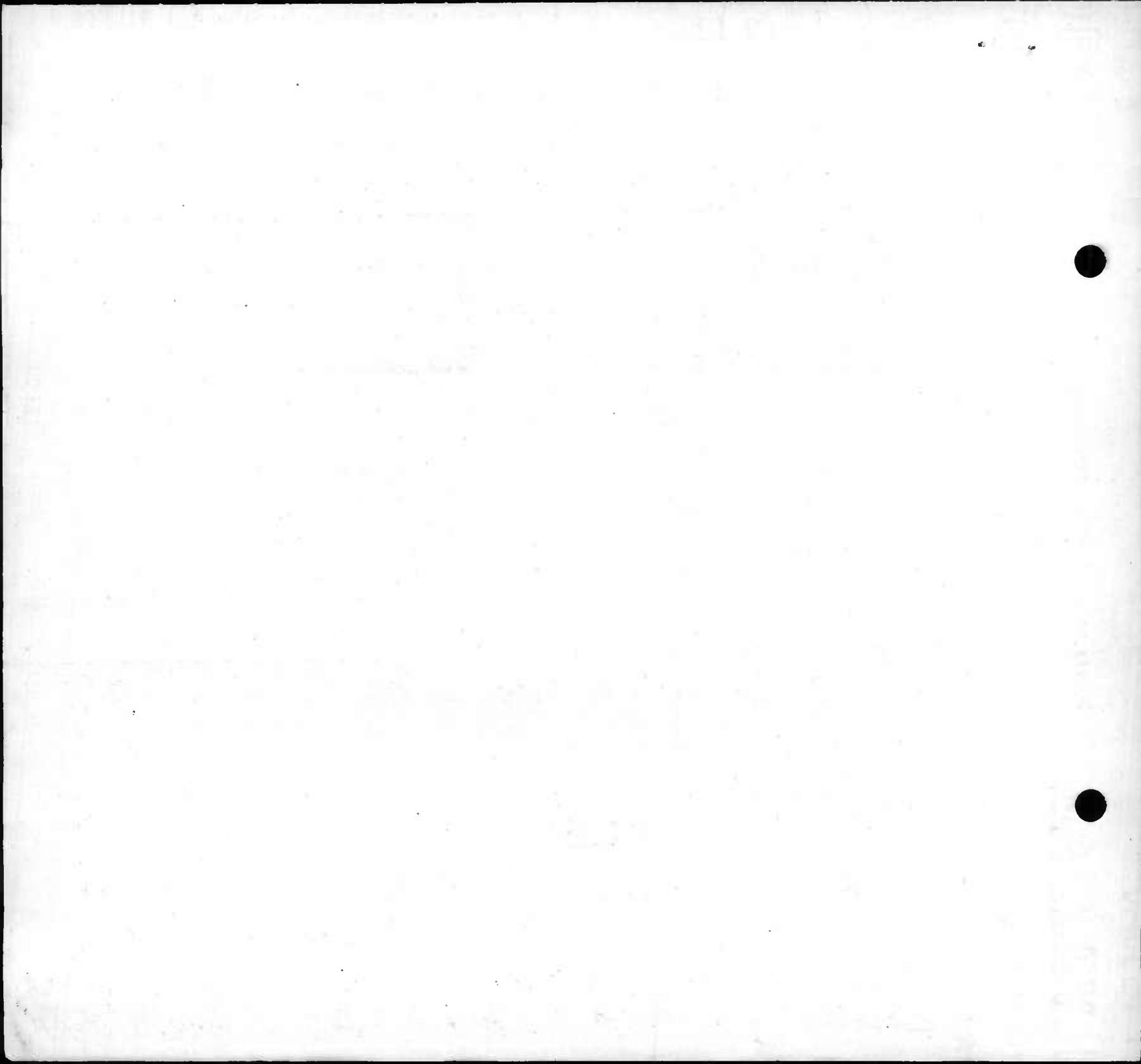
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print) Morris Mitnick		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1729 N. Bentalou St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 2 69 1:20 p. M.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 1503	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 76 XXX	
11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE		14B. KIND OF BUSINESS OR INDUSTRY FURNITURE CO.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 212-01-0474	
18. INFORMANT MRS. FANNIE MITNICK, 1729 N. BENTALOU ST #16		ADDRESS	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED 12/2/69			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-4-69	
24C. NAME OF CEMETERY or CREMATORY AITZ CHAIN		24D. LOCATION (City, town, or county) (State) WASHINGTON BLVD. Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR J. E. F. J. E. F.	
25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. Reisterstown Rd.		ADDRESS 6010	

ACADEMY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-425 69 12034		BALTIMORE CITY HEALTH DEPARTMENT		69 12034	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Zolman Harry Millison		December 3, 1969 2 ⁴¹ / ₄ M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 2740	
6301 Park Heights Ave		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6301 Park Heights Avenue					
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 12, 1905	9. AGE (In years last birthday) 64
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retail		Self Employed		Heat Mills, Md	
13. FATHER'S NAME Charles Millison		14. MOTHER'S MAIDEN NAME Rose Sachs		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 241-22-1032		17. INFORMANT Mrs Esther Millison - 6301 Park Hts.	
18. 190X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH melanoma of left eye with metastases		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mos.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 4/30/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED melanoma of eye		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 1949 to Dec 3 1969, that (I) (we) last saw the deceased alive on Dec 2 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Louis E. Nice M.D.		23B. DATE SIGNED 12/3/69		23C. PHYSICIAN'S NAME (Type) Louis E. NICE M.D.	
23D. ADDRESS 920 St. Paul St Baltimore Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 4/69		24C. NAME OF CEMETERY or CREMATORY Pine Lake	
24D. LOCATION Baltimore, Maryland		24E. NAME OF REGISTRAR Sol Leedom			
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR Sol Leedom		25C. FUNERAL DIRECTOR Mrs - 6010 Reist Rd	



1
L-000
E-120

69 12035

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12035

BIRTH NO.

1. NAME OF DECEASED (Type or Print) (James Edward Lee) alias - Willey Epps		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 11 22 69 4:40 a. m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore General Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 11 22 69 4:40 a. m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2201		6. SEX male 7. RACE colored 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Sept. 10, 1925		10. AGE (In years last birthday) 44	
11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Unknown		17. SOCIAL SECURITY NO. 229-20-1564	
18. INFORMANT Mrs. Dorothy Wood		ADDRESS 1604 Greenville St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 571.8 I Fatty metamorphosis of liver DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		DATE SIGNED 11/22/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12-5-69	
24C. NAME OF CEMETERY or CREMATORY Woodland, Richmond, Va.		24D. LOCATION (City, town, or county) (State) Richmond, Virginia	
25A. DATE REC'D BY HEALTH DEPT. DEC 5 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR J. D. Moss		ADDRESS Richmond, Virginia	

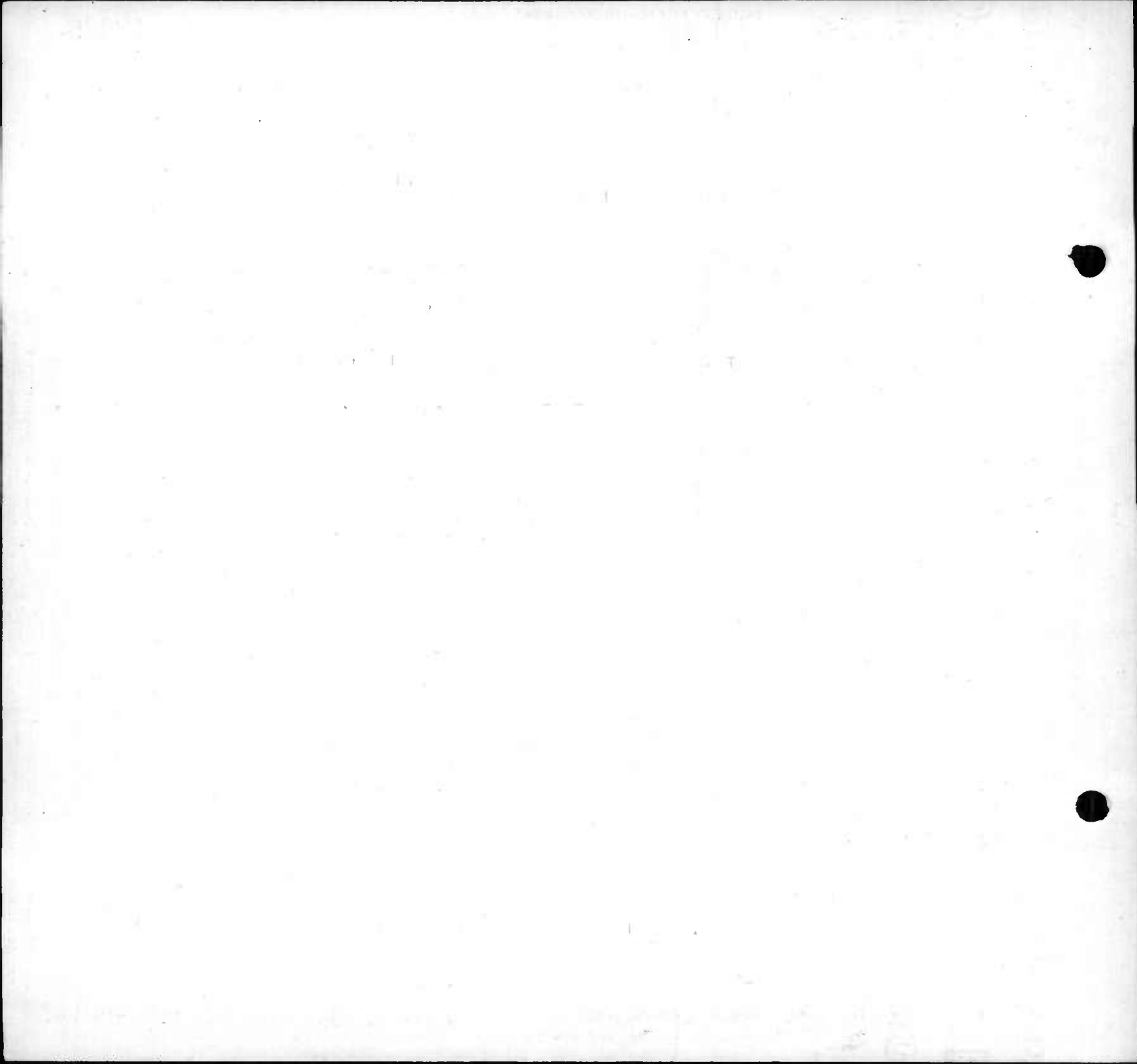
W. G. CAMPBELL & SONS

VALLEY ROAD, CO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-252		69 12036		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12036	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) TAYLOR, WASHINGTON				2. DATE AND HOUR OF DEATH 12-6-69 7:35PM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1506 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2021 Braddish Avenue			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-5-08	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contestant, Wage Adjudicator		10B. KIND OF BUSINESS OR INDUSTRY Social Security		11. BIRTHPLACE (State or foreign country) Miss.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME TAYLOR WASHINGTON				14. MOTHER'S MAIDEN NAME BINETTE CRUMP			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 563-38-9300		17. INFORMANT ADDRESS Mrs. Carol F. Jetter 2021 Braddish Ave.			
18. 274 XI DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CHRONIC RENAL FAILURE GOUTY Nephropathy HYPERTENSION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Myocardial Infarction, CHF, Anemia							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/23 1969 to 12/6 1969 , that (I) (we) last saw the deceased alive on 12/6 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Harvey G. Klein				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/6/69	
23C. PHYSICIAN'S NAME (Type) HARVEY G. KLEIN				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-69		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE RECD BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR W. J. Taylor, Jr.		25C. FUNERAL DIRECTOR Nutter Funeral Home		ADDRESS 3035 W. North Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520 69 12037		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12037	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Paul D. Tennessee			12-5-69 9:20 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 Bolton Hill Nursing & Convalescent Center			Maryland 1206		
C. CITY OR TOWN			D. INSIDE CITY LIMITS?		
Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER			302 East 201/2 Street		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
Male	Negro	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	2-2-91	78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. PLACE OF BIRTH (State or foreign country)		
			va		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY?		
			USA		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
unpron			unpron		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
			213-09-5094		Medford J. Perkins 2509 Chelton Ave
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
436.9 I			Cerebro-vascular accident		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
			(B) arteriosclerosis several months		
			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11-18-1967 to 12-5-1967, that (I) (we) last saw the deceased alive on 12-3-1967 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
E. Ellsworth Cook M.D.				12-6-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
E. Ellsworth Cook M.D.				2431 Maryland Ave Balto. 21218.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		12-8-69		Mt Auburn	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 8 1969		E. Ellsworth Cook		2302 W. North Ave	

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69 12038

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12038

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) ERVIN BUSTER ATWATER		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1519 W. Lexington Street		3. DATE PRONOUNCED DEAD Month Day Year Hour December 4, 1969 11:00 A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1901	
9. DATE OF BIRTH Nov 15 - 1932		10. AGE (In years last birthday) 37 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Orange Co. NC		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) No		17. SOCIAL SECURITY NO. 044-42-8974	
18. INFORMANT Pauline Atwater		ADDRESS 1519 W. Lexington Street	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Bronchopneumonia with abscess formation		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED December 4, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-69	
24C. NAME OF CEMETERY or CREMATORY Chapell Hill Cal.		24D. LOCATION (City, town, or county) (State) North Carolina	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Charles E. Taylor	
25C. FUNERAL DIRECTOR Chapell Hill Funeral Home N.C.		ADDRESS	

C-630 69 12039

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12039

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Warren Coward		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 1 69 10:10 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home and Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 1 69 10:10 p.m.	
6. SEX male		7. RACE colored	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8-5-1908		10. AGE (In years last birthday) 61	
11. BIRTHPLACE (State or foreign country) WASHINGTON DC		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALBERT COWARD		14. MOTHER'S MAIDEN NAME CLARA THOMPSON	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) N		18. SOCIAL SECURITY NO. 242-03-5340	
19. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type): Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED: 12/2/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12-8-69	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State) Washington DC	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR John E. Taylor	
25C. FUNERAL DIRECTOR JEO Wilson		ADDRESS 1000 BEANTLEY N.C.	

ACADEMY BOARD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-120		69 12040		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12040	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Tabbs, William</i>			
2. DATE AND HOUR OF DEATH <i>12-3-69- 11:25</i> M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1303</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>1574 Richland St.</i>				FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Harbor View n e c</i>			
5. SEX <i>Male</i>		6. RACE <i>Negro</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>2-8-07</i>	
9. AGE (In years last birthday) <i>62</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life. <i>Retired</i>)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Sheldon Tabbs</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Matthews</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>214-16-8095</i>		17. INFORMANT <i>Helen V Anderson</i>		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. <i>5582X I</i> CAUSE OF DEATH				DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>@ Renal Failure, chronic</i>			
DUE TO, OR AS A CONSEQUENCE OF:				(B) <i>@ Azotemia 2d to C</i>			
DUE TO, OR AS A CONSEQUENCE OF:				(C) _____			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Nov. 15</i> 19 <i>69</i> to <i>Dec. 3</i> 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>Dec. 3</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Adoracion B. Paulino</i> DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Dec. 4, 1969</i>	
23C. PHYSICIAN'S NAME (Type) <i>Adoracion B. Paulino</i> DEGREE				23D. ADDRESS <i>1213 light street 21230</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12-8-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Burial Care Center</i>		24D. LOCATION (City, town, or county) <i>Lanai mel</i> (State) <i>me</i>	
25A. DATE RECD BY HEALTH DEPT. <i>DEC 8 1969</i>		25B. NAME OF REGISTRAR <i>John E. Taylor</i>		25C. FUNERAL DIRECTOR <i>E. J. Wilson</i>		ADDRESS <i>5191</i>	

1
M-600 69 12041 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 12041

BIRTH NO.

1. NAME OF DECEASED (Type or Print) TOWNSEND MOORE (Townsend)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12 4 69 4:15 pm	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2905 Garrison Blvd.		3. DATE PRONOUNCED DEAD Month Day Year Hour Dec. 4, 1969 4:15 p.m.	
6. SEX Male		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1538	
7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Nov 17-1884	10. AGE (In years lost birthday) 85	E. STREET AND NUMBER 2905 Garrison Blvd.	
11. BIRTHPLACE (State or foreign country) Balto Md	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME unknown	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES		17. SOCIAL SECURITY NO. 262-10-1248	
		18. INFORMANT Robert Down ADDRESS	

19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: Tsidore Mihalakis, M.D. DATE SIGNED: 12/5/69

EXAMINER'S NAME (Type): Tsidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-9-69	24C. NAME OF CEMETERY or CREMATORY Baltimore Cal	24D. LOCATION (City, town, or county) (State) Baltimore Md
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969	25B. NAME OF REGISTRAR John E. Fisher, M.D.	25C. FUNERAL DIRECTOR ADDRESS Elroy O. Baker 1000 Cranberry	

1000

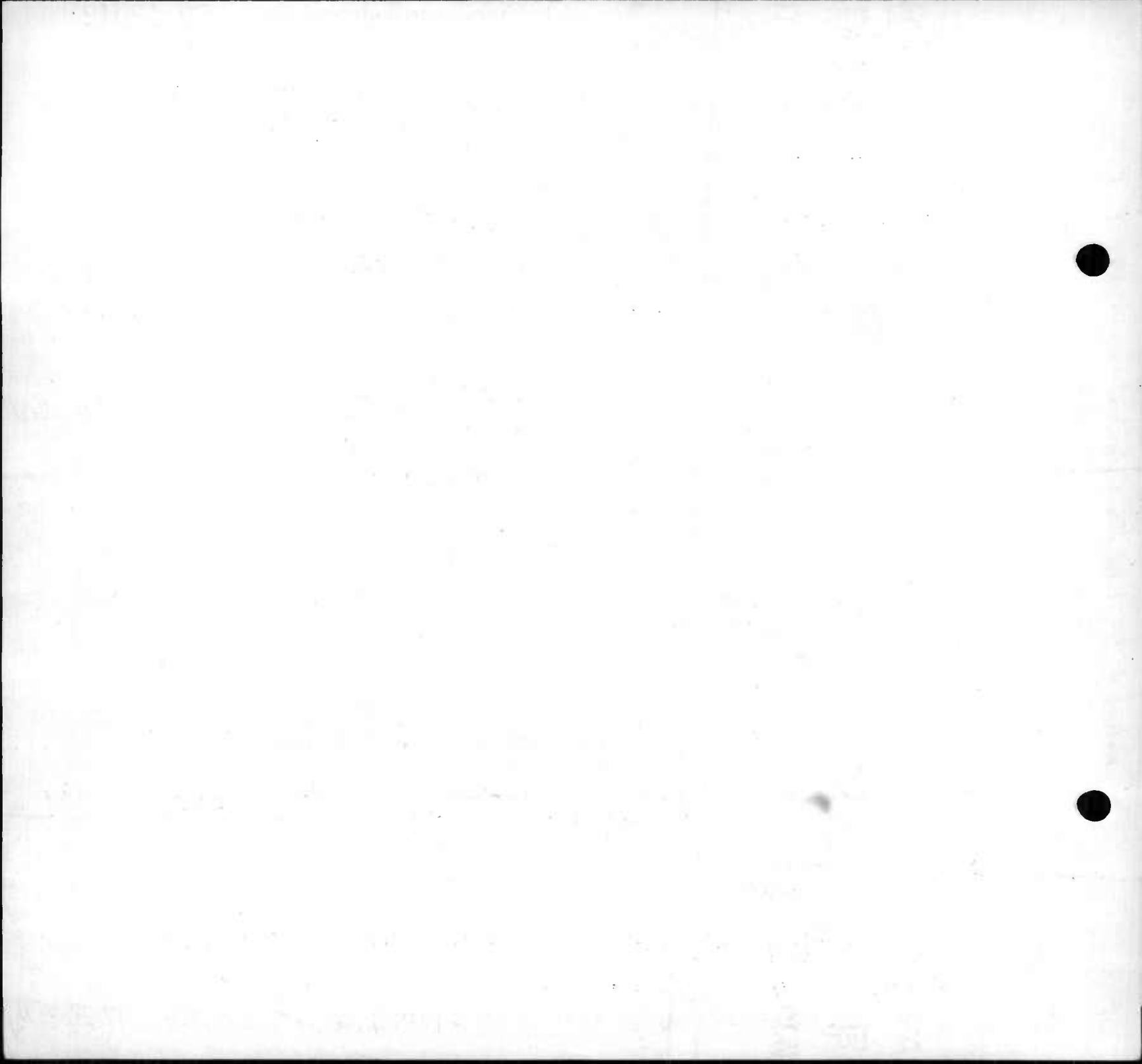
Not May 25
Cable only
Subject
Yes
as now that time
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Cable only
Subject
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		69 12042		69 12042	
BIRTH NO. <u>L-236</u>		69 12042		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Theodore Lasiter</u>		2. DATE AND HOUR OF DEATH <u>November 19, 1969</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>D.O.A.</u>		A. STATE <u>Md</u>		B. COUNTY <u>Baltimore</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>Md General Hospital</u>		E. STREET AND NUMBER <u>1908 Entaw Pl</u>			
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/17/1883</u>	9. AGE (In years last birthday) <u>86</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>
11. BIRTHPLACE (State or foreign country) <u>Harford, Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-10-2193</u>	
17. INFORMANT <u>Mrs. Virginia Jones</u>		ADDRESS <u>1908 Entaw Pl Baltimore</u>			
18. <u>4-12-4-1</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>A.S.C.V.D.</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>10-28-</u> <u>1966</u> to <u>11-14-</u> <u>1969</u> , that (I) (we) last saw the deceased alive on <u>11-14-</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C.R. Campbell, M.D.</u>		23B. DATE SIGNED <u>11-24-69</u>			
23C. PHYSICIAN'S NAME (Type) <u>C.R. Campbell, M.D.</u>		23D. ADDRESS <u>1618 W. North Ave. Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>11/23/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1969</u>		25B. NAME OF REGISTRAR <u>J. B. Johnson</u>	
25C. FUNERAL DIRECTOR <u>1908 Entaw Pl Baltimore</u>		ADDRESS			

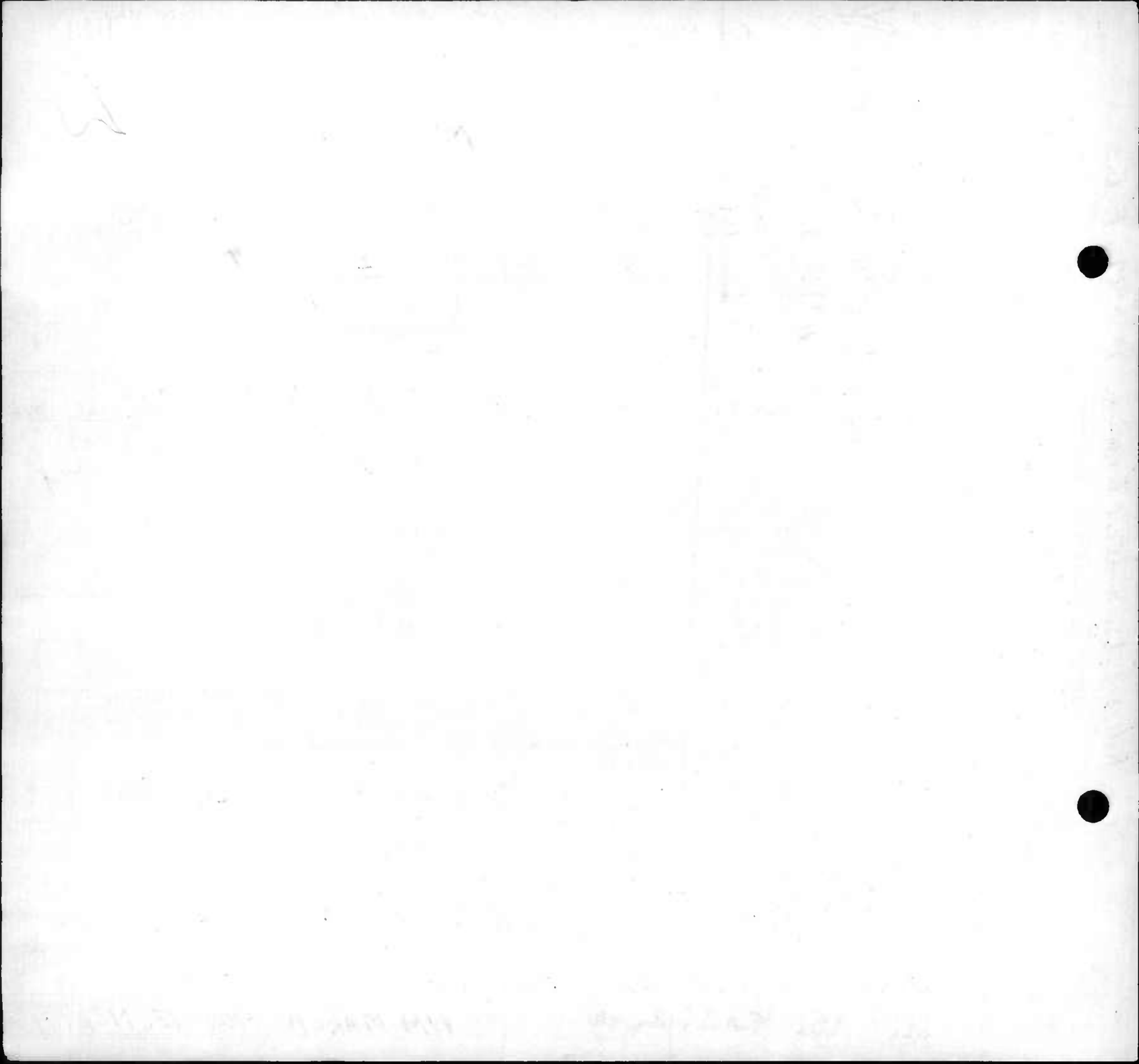


Released by Medical Examiner 12-6-69 E.L.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

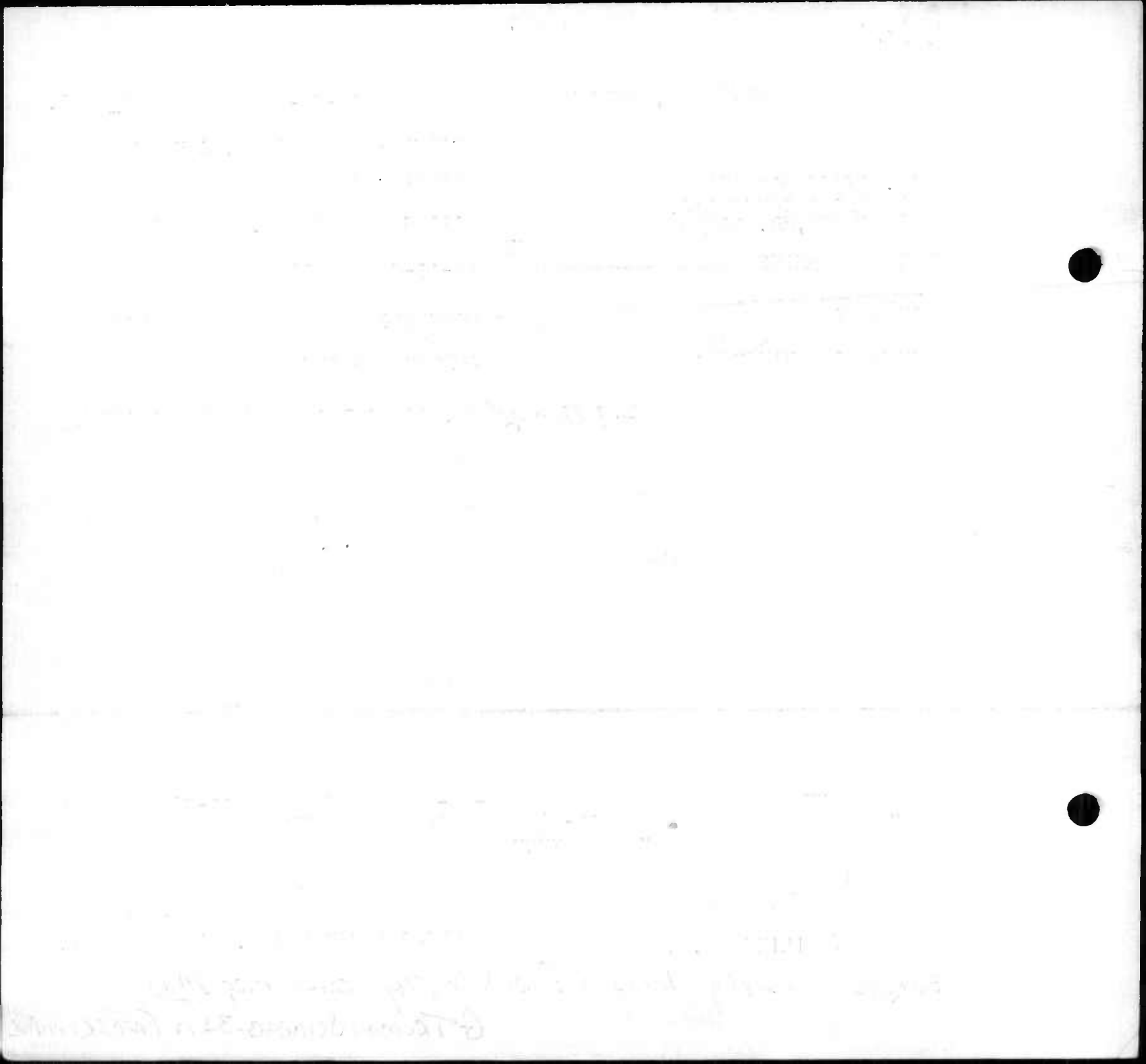
C-530		69 12043		CERTIFICATE OF DEATH		REG. NO. 69 12043					
BIRTH NO.				1. NAME OF DECEASED (Type or Print) (WILLIE) YORK CANDY.				2. DATE AND HOUR OF DEATH 12-6-69 5 45 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1203				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL				E. STREET AND NUMBER 400 E. LORRAINE AVE.							
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-1-95		9. AGE (In years last birthday) 74		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME —				14. MOTHER'S MAIDEN NAME —							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. 217-07-5615		17. INFORMANT WALTER CANDY ADDRESS 400 E. LORRAINE AVE					
18. 4/12/71 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH CVA				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days.			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(B) DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES				(C) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				DEHYDRATION							
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) this hospital attended the deceased from December 6 19 69 to December 6 19 69 , that (I) (we) last saw the deceased alive on December 6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Enrique Cipriani MD.								Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-6-69	
23C. PHYSICIAN'S NAME (Type) ENRIQUE CIPRIANI MD.								23D. ADDRESS 33rd and Calvert St.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 12/10/69		24C. NAME OF CEMETERY or CREMATORY BALTO NAT. CEM.		24D. LOCATION (City, town, or county) (State) BALTO MD			
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969				25B. NAME OF REGISTRAR John E. Jones, MD.		25C. FUNERAL DIRECTOR W.A. BARCH		ADDRESS 928 E. NORTH AVE			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

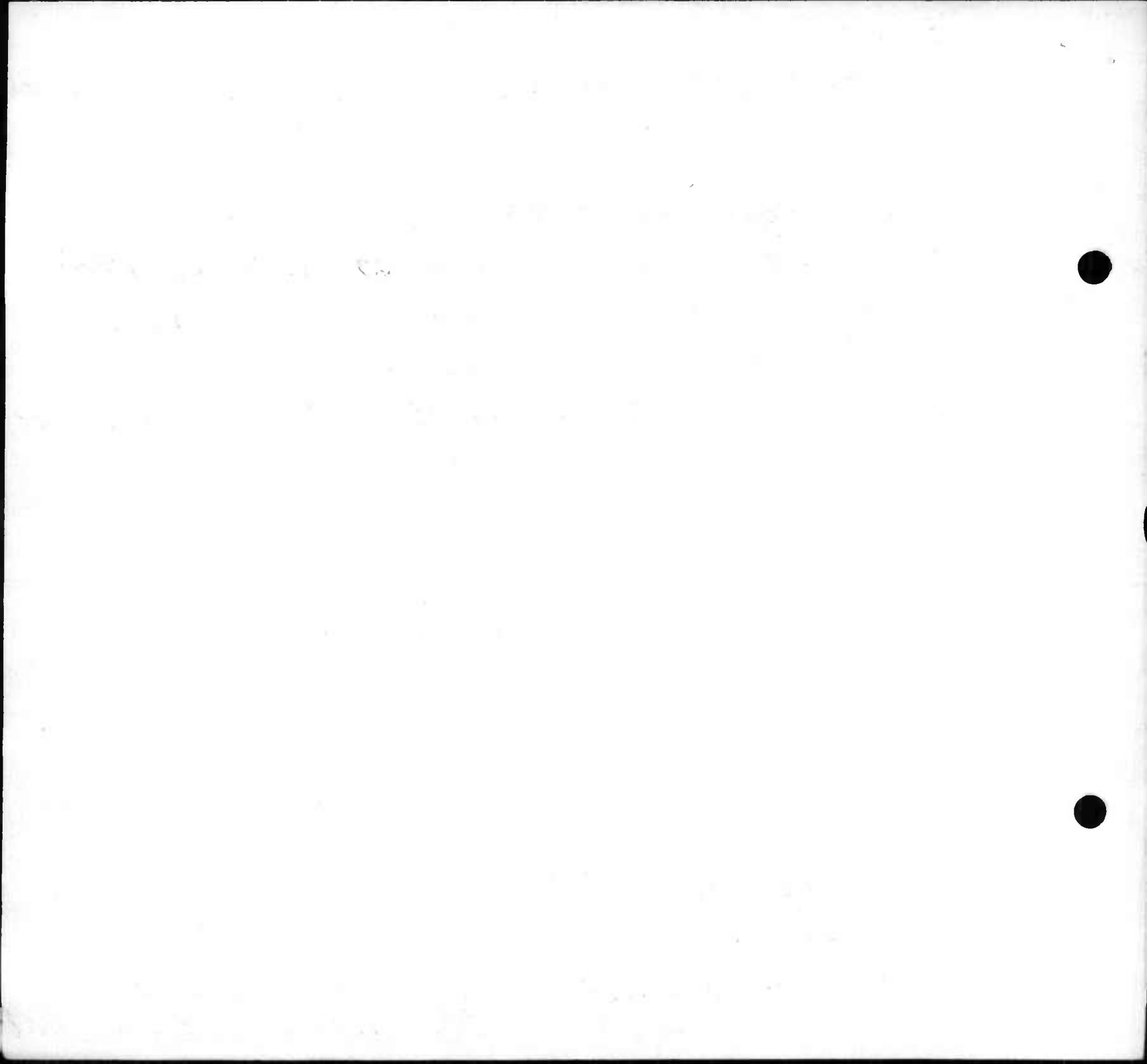
W-330		69 12044		BALTIMORE CITY HEALTH DEPARTMENT		69 12044	
CERTIFICATE OF DEATH				X		REG. NO.	
1. NAME OF DECEASED (Type or Print) WHITEHEAD, STEVEN				2. DATE AND HOUR OF DEATH 12-04-69 1 7 20 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MD. 21228				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTO. COUNTY 5300			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 113 GLENMORE AVE.		21228	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07-13-52	9. AGE (in years last birthday) 17	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME CHARLES WHITEHEAD				14. MOTHER'S MAIDEN NAME AUDREY MURPHY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 217-58-475		17. INFORMANT ST. AGNES RECORD WILKENS & CATON	
18. E 917X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, which rise to the above cause (A) adding the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MONILIAL PNEUMONIA			
				(B) DUE TO, OR AS A CONSEQUENCE OF: SEPTICEMIA			
				(C) RENAL FAILURE			
				TRANSECTION 2ND PART DUODENUM			
19A. DATE OF OPERATION 9-28-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1570 Frederick Rd		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 5300			
21D. TIME OF INJURY (APPROX.) 9-28-69		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? playing football, someone stepped on stomach			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9-28- 1969 to 12-04 1969 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12-04 1969 and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.							
23A. SIGNATURE M. Cabiling				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) M. CABILING M.D.				23D. ADDRESS WILKENS & CATON AVE. BALTIMORE, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-8-69		24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR J. E. Taylor		25C. FUNERAL DIRECTOR G. TRUMAN SCHWAB-3514 FRANKLIN AVE		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-252 69 12045		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12045	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) EISENSTEIN, MORRIS		2. DATE AND HOUR OF DEATH 12-4-69 12 Noon M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTO		E. STREET AND NUMBER 6852 PARSONS AVE			
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 6-30-90	10. AGE (In years last birthday) 79	11. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Bus. (Owner)		11. BIRTHPLACE (State or foreign country) RUSSIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eisenstein		14. MOTHER'S MAIDEN NAME Balin?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 212-282395A		17. INFORMANT Mr. Leonard Eisenstein ADDRESS 6852 Parsons Ave #67	
18. CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). A. S. C. V. D. & Anemia					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (If in Baltimore City, give exact location)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-1-19 69 to 12-4-19 69 that (I) (we) last saw the deceased alive on 12-4-19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Atalpen M.D.		23B. DATE SIGNED 12-4-69		23C. PHYSICIAN'S NAME (Type) CARLOS S. VALLEJO M.D.	
23D. ADDRESS SINAI HOSPITAL OF BALTO.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-5-69		24C. NAME OF CEMETERY OR CREMATORY Sinai Israel Southern Ave. Balto. Maryland	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR E. Taylor M.D.		25C. FUNERAL DIRECTOR Dr. Germaine & Bros. 6000 Parkview Rd.	



K-500

69 12046

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12046

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

GEORGE V. KEENE

2. DATE
OF DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(If not in hospital or institution, give street
address or location)

SINAI HOSPITAL (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

December 2, 1969

11:00 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

2831

6. SEX

Male

7. RACE

White

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

11-16-12

10. AGE (In years
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

4119 Rockfield Avenue #21215

11. BIRTHPLACE (State or foreign country)

NEW YORK

12. CITIZEN OF
WHAT COUNTRY?

USA

13. FATHER'S NAME

JACK KEENE

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

RETIRED

14B. KIND OF BUSINESS OR INDUSTRY

APPRENTICE TYPE SETTER

15. MOTHER'S MAIDEN NAME

ANNA ?

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL
SECURITY NO.

082-07-7846

18. INFORMANT

ADDRESS

MRS. GERTRUDE KEENE, 3164 JEFFLAND ROAD #07

19.

E8901X

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Smoke and soot inhalation incident to

(A) IMMEDIATE CAUSE conflagration
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

4119 Rockfield Avenue

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

12-2-69 10:30 P. m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Conflagration

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Ronald N. Kornblum, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/3/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12-5-69

24C. NAME OF CEMETERY or CREMATORY

CHITZLIK
EXXAK AMUNO

24D. LOCATION (City, town, or county) (State)

W. ROGERS AVE., MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1969

25B. NAME OF REGISTRAR

John E. Taylor, M.D.

25C. FUNERAL DIRECTOR

SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD

100-100000

100-100000

100-100000

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-620		69 12047		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12047		
BIRTH NO.										
1. NAME OF DECEASED (Type or Print) MELVIN PIERCE					2. DATE AND HOUR OF DEATH 12/4/69 13.30 a.m.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNIVERSITY OF MARYLAND HOSPITAL					C. CITY OR TOWN RANDALSTOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
38					E. STREET AND NUMBER 8710 MEADOW HTS. #21133					
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/30/17		9. AGE (In years lost birthday) 52		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT					10B. KIND OF BUSINESS OR INDUSTRY XXXXXXXXXXXXXXXXXXXX XXXXXXXXXXXX US GOVT.		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HYMAN PIERCE					14. MOTHER'S MAIDEN NAME BELLA ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] YES, WWII ARMY					16. SOCIAL SECURITY NO. 215-07-1948		17. INFORMANT MRS. PEARL PIERCE, 8710 MEADOW HEIGHTS ROAD			
18. CAUSE OF DEATH										
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRAL HYPOXIA CARDIAC ARRHYTHMIA (B) DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION (C) DIABETES MELLITUS					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17 days 17 days 17 days										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 11/17/69 to 12/4/69 that (I) (we) last saw the deceased alive on 12/4/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE A. M. Doyle					23B. DATE SIGNED 12/4/69			23C. PHYSICIAN'S NAME (Type) DR. A. M. DOYLE		
23D. ADDRESS UNIVERSITY HOSPITAL										
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)			
BURIAL		12-5-69		BNAI ISRAEL, SOUTHERN AVE.			BALTO. MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS		
DEC 8 1969		J. L. BROS.			SOL LEVINSON			J. L. BROS. 6010 REISTERSTOWN ROAD		

12/15/69 - Correction form from funeral director. *ABC*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12048		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12048	
P-530		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margie Pound		2. DATE AND HOUR OF DEATH 12/3/69 8:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Imp. Baltimore C. CITY OR TOWN Dundalk 21222 D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3483 McSHANE WAY			
5. SEX Female	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/91	9. AGE (In years lost birthday) 78	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME JACK MC CARTY		14. MOTHER'S MAIDEN NAME SARAH TRIGGER		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-1253		17. INFORMANT Daughter: ADDRESS 21222 Mrs. Mary Lyell 3483 McShane Way Dundalk, Md.	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory Arrest (B) Metastatic Carcinoma one year (C) Invasive Cervical Ca 14 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH —	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11/19 1969 to 12/3 1969 , that (1) (we) last saw the deceased alive on 12/3 1969 and that (1) (my) (own) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
23A. SIGNATURE R. Vermillion, M.D.				23B. DATE SIGNED 12/5/69	
23C. PHYSICIAN'S NAME (Type) R. Vermillion, M.D.		23D. ADDRESS The Johns Hopkins Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/69		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park	
24D. LOCATION Dorsey, Maryland		24E. LOCATION (City, town, or county) (State) Dundalk, Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR John G. Duda	
25D. ADDRESS 27922 Wise Ave. Dundalk, Md. 21222					

87

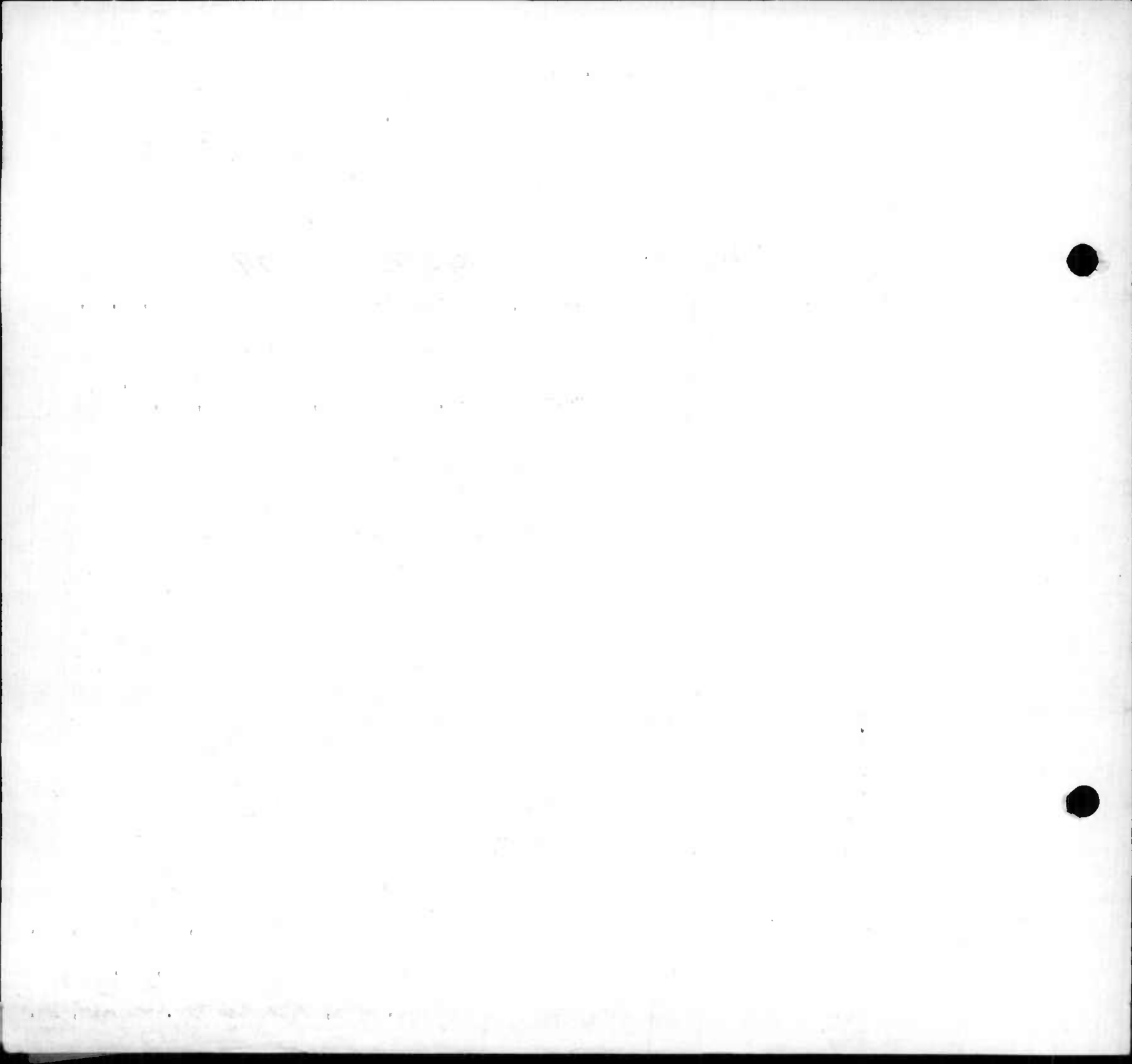
18/12/13

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FUNERAL DIRECTOR: IMPORTANT

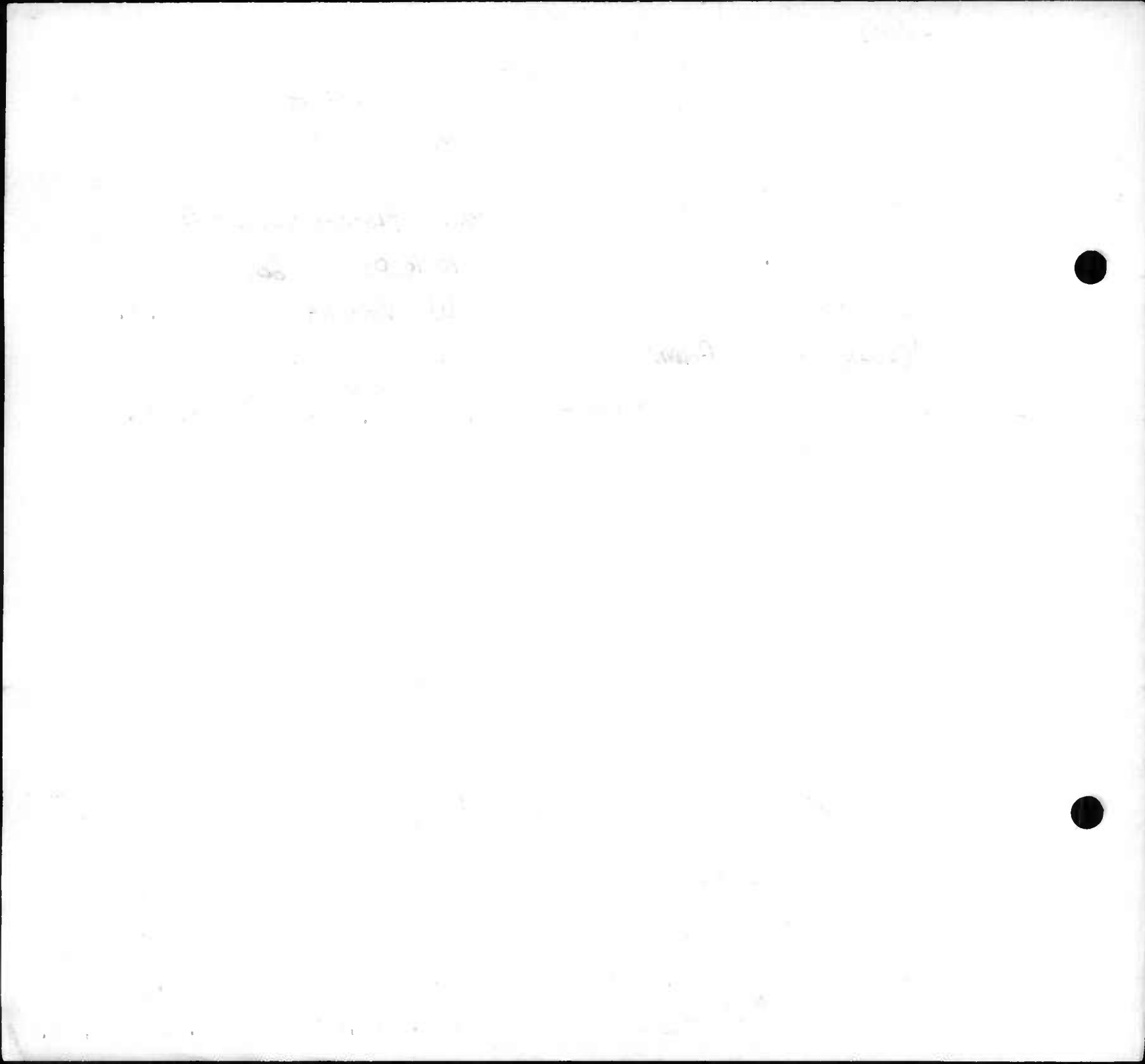
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-200		69 12049		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12049	
1. NAME OF DECEASED (Type or Print) HASE, HARRY		2. DATE AND HOUR OF DEATH 11/15 12/4/69							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)		A. STATE Md.		B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION PLEASANT MANOR NURSING HOME		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4615 PARK HOLE AVENUE		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 7504 IROQUOIS ROAD									
5. SEX male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/3/90	9. AGE (In years last birthday) 79	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Ernest Hase		14. MOTHER'S MAIDEN NAME Ella Bingham							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-8757		17. INFORMANT Mrs. Berta Hase, Baltimore, Md. 21219		ADDRESS 7504 Iroquois Rd.			
18. 412.41		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Cardiac arrest				3 min.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Arteriosclerotic cardiovascular disease							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Parkinson's Disease				years			
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 19 to 12-4 1969 , that (I) last saw the deceased alive on 12-3 1969 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE Frank G. Kuehn		23B. DATE SIGNED 12/4/69		23C. PHYSICIAN'S NAME (Type) FRANK G. KUEHN		23D. ADDRESS Plesant Manor Nursing Home, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/69		24C. NAME of CEMETERY or CREMATORY Meadowridge Memorial Park		24D. LOCATION (City, town, or county) (State) Dorsey, Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-400		69 12050		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12050	
CERTIFICATE OF DEATH							
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				Virginia Alice Kelly			
2. DATE AND HOUR OF DEATH				12-4-69 6. A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
48 MARYLAND GENERAL HOSPITAL				MD Baltimore 5300			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
Female		Cau.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10-16-03	
9. AGE (In years last birthday)		10. UNDER 1 Yr. Months Days		11. UNDER 24 Hrs. Hours Min.		12. CITIZEN OF WHAT COUNTRY?	
66						U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
Housewife							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William. Burr Godwin				Fannie May Fancier			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				219-26-5181			
17. INFORMANT Husband: 8200 Bletzer Road				Mr. Hubert B. Kelly Dundalk, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)				12 hours			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE Myocardial infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
				(B) OVARIAN CA. & CARCINOMATOSIS. 2 years			
				(C) INTESTINAL OBSTRUCTION 20 & (d) 14 days			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				DIABETES HELLITUS			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
11-25-69		INTEST. OBS		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (this hospital) attended the deceased from 12/24 19 69 to 12-4 19 69 that (I) (we) last saw the deceased alive on 12-4 19 69 and that (my) (our) opinion death occurred on the date and hour and from the causes noted above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. H. MATHER.				12-4-69.			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
J. H. MATHER.				MARYLAND GENERAL HOSPITAL.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/6/69		Bel Air Memorial Gardens		Bel Air, Maryland	
25A. DATE REC'D BY HEALTH DEPT		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 8 1969		John E. Kelly		John A. Duda		7922 Wise Ave. Dundalk, Md.	



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12051

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Marie Burakiewicz		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Hopkins Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 1 69 1:03 p. M.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 701	
9. DATE OF BIRTH 3/24/1932		10. AGE (in years last birthday) 37	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Edward Lacey		14. STREET AND NUMBER 3023 E. Monument St.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		14B. KIND OF BUSINESS OR INDUSTRY English-American Tailoring	
15. MOTHER'S MAIDEN NAME Marie Havlik		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 218-28-0616		18. INFORMANT ADDRESS Frank Burakiewicz, husband, above	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Werner U. Spitz</i> M.D. EXAMINER'S NAME (Type) Werner U. Spitz M.D. Deputy Chief Medical Examiner CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/2/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/5/69	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR John P. Taylor	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2001 E. Madison St.	

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U.S. DEPARTMENT OF STATE

VISA

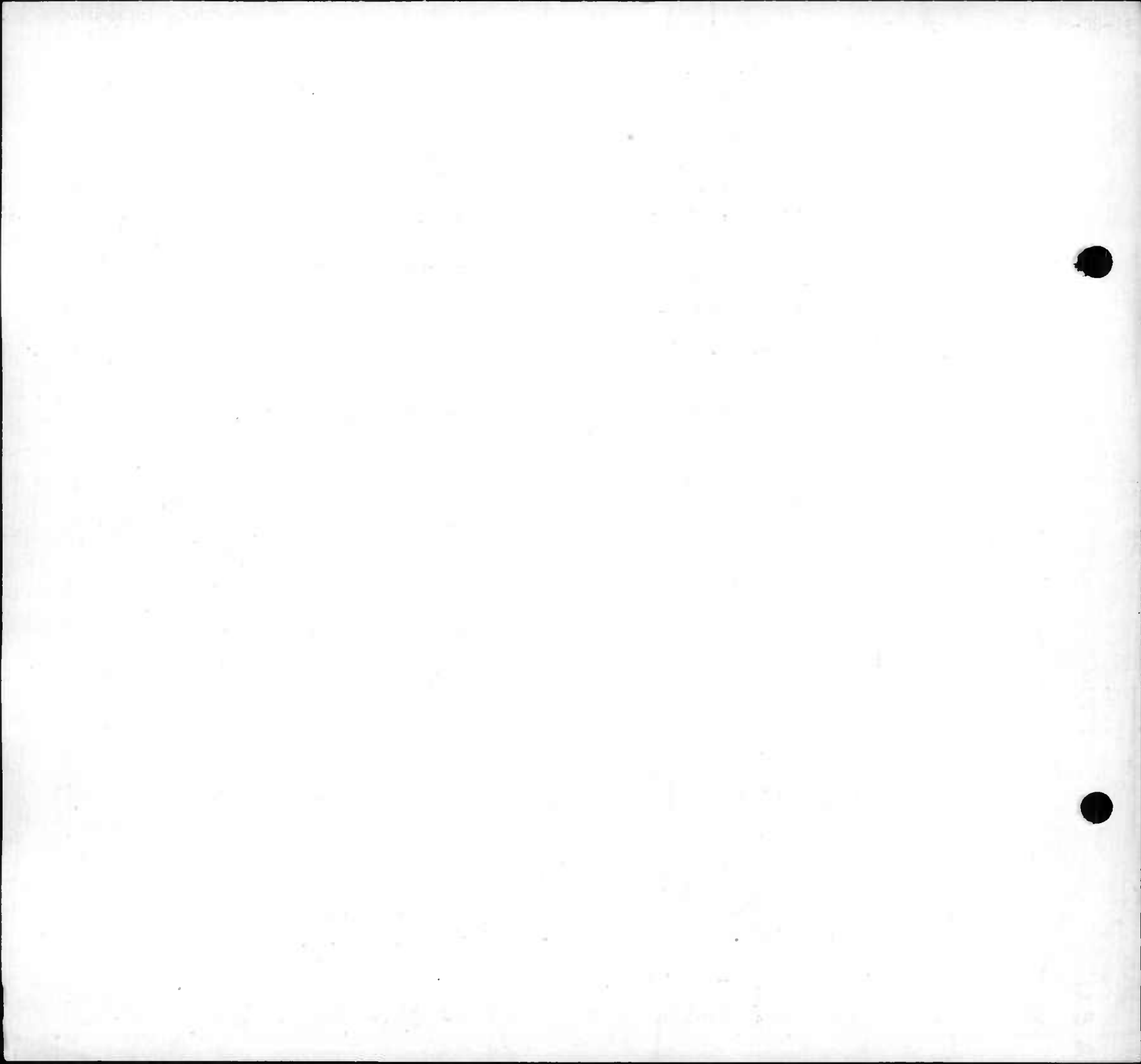
ENTRY PASSPORT

U.S. DEPARTMENT OF STATE

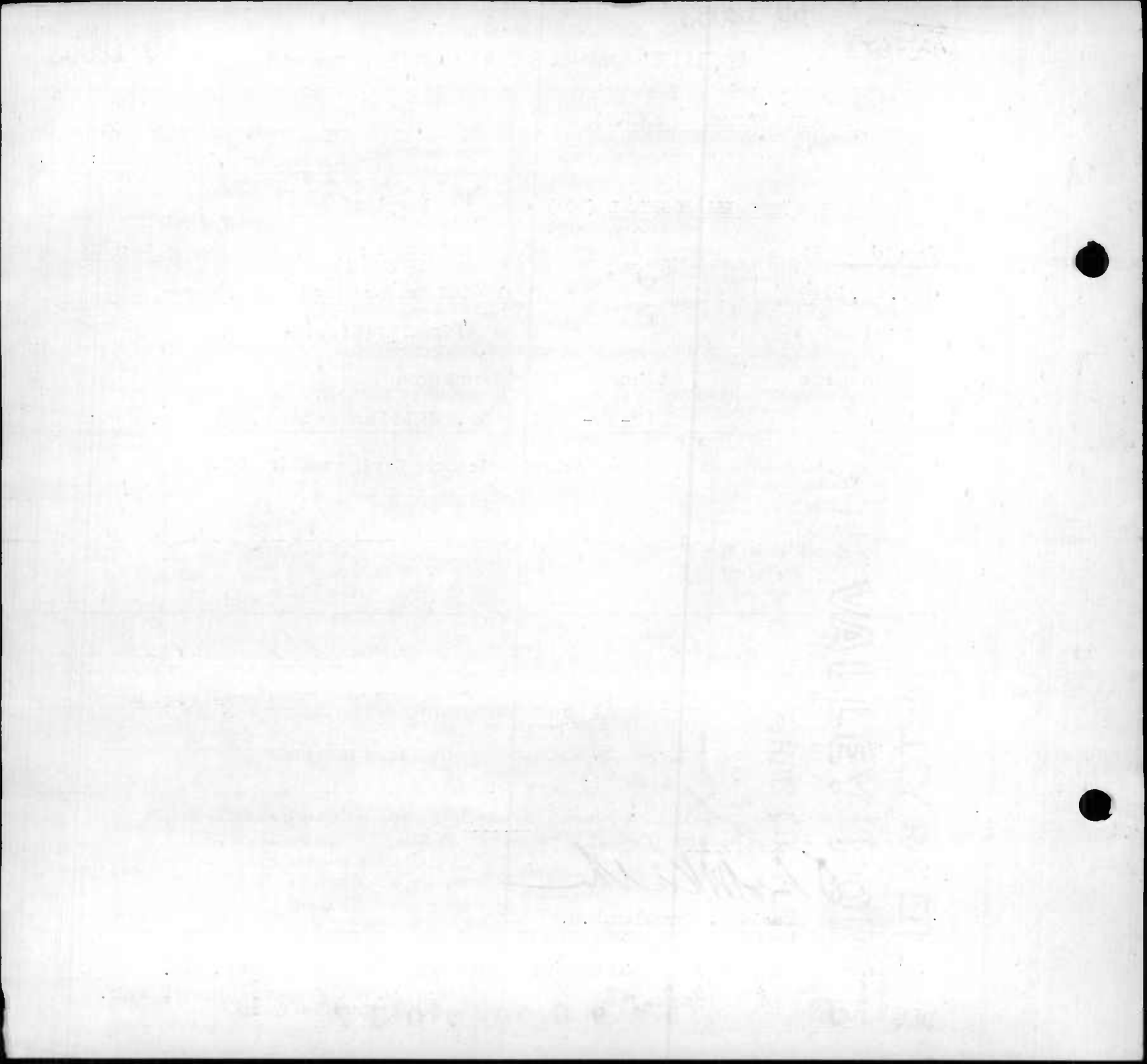
[Signature]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12052	
M-324 69 12052		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Edward William E. MITCHELL	
2. DATE AND HOUR OF DEATH 12/3/69 5 P. M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION 31		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 702		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 531 Lakewood Avenue 21205 007		5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 11-19-84 9. AGE (In years last birthday) 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Black Smith 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas H. Mitchell		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT BCH-Records		ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
18. 448X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE G.I. BLEED DUE TO, OR AS A CONSEQUENCE OF: 4 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) MULTIPLE TELANGIECTASIAS DUE TO, OR AS A CONSEQUENCE OF: 4 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE MANY YEARS	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3/21 19 69 to 12/3 19 69, that (we) last saw the deceased alive on 12/3 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Dennis W. Bleakley MD		23B. DATE SIGNED 12/3/69	
23C. PHYSICIAN'S NAME (Type) Dennis W. Bleakley MD		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/69	
24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR 9 0 0 0	
25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2601 E. Madison St.	



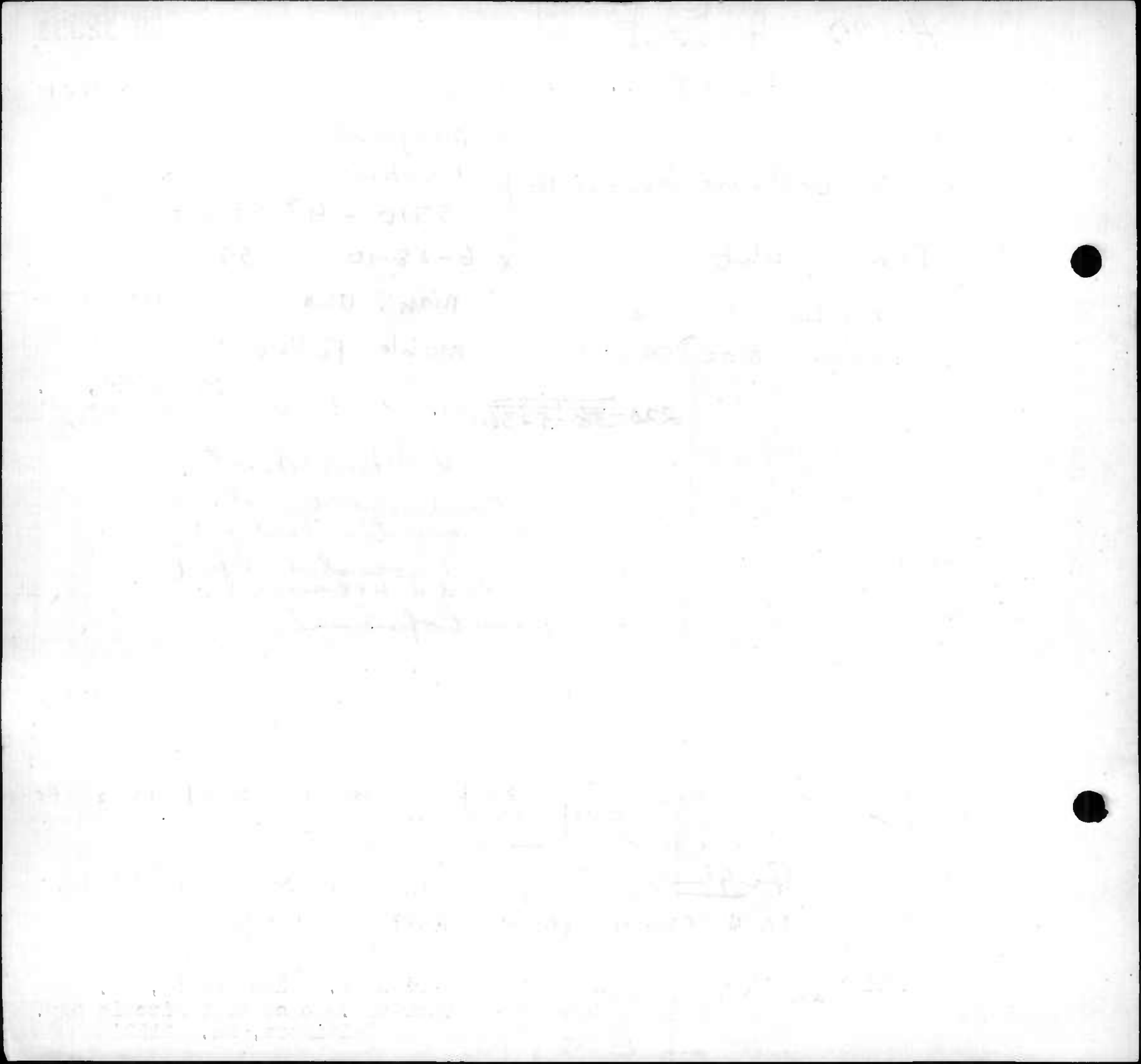
BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		J. CARRIE FETTER (WOLFE)		2. DATE OF DEATH		Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		3. DATE PRONOUNCED DEAD		Month Day Year Hour		December 3, 1969 12:12 A.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
UNION MEMORIAL HOSPITAL (DOA)				Maryland		906	
6. SEX	7. RACE	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH	10. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)		E. STREET AND NUMBER			
Oct. 16, 1916	53	Maryland		3102 Harford Road			
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME	
		Alfred Jefferson		Housewife		unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS	
		219-30-8621		Dr. William Fetter, husband, above			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
412.4 I		Arteriosclerotic Cardiovascular Disease					
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(C) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No)			
2				yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED		22F. HOW DID INJURY OCCUR?			
		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		DATE SIGNED			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		12/3/69			
Ronald N. Kornblum, M.D.		ASSOCIATE MEDICAL EXAMINER					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/5/69		Baltimore Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 8 1969		J. B. E. Taylor, M.D.		Schimunek Funeral Home, Inc.		3331 Brenns Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

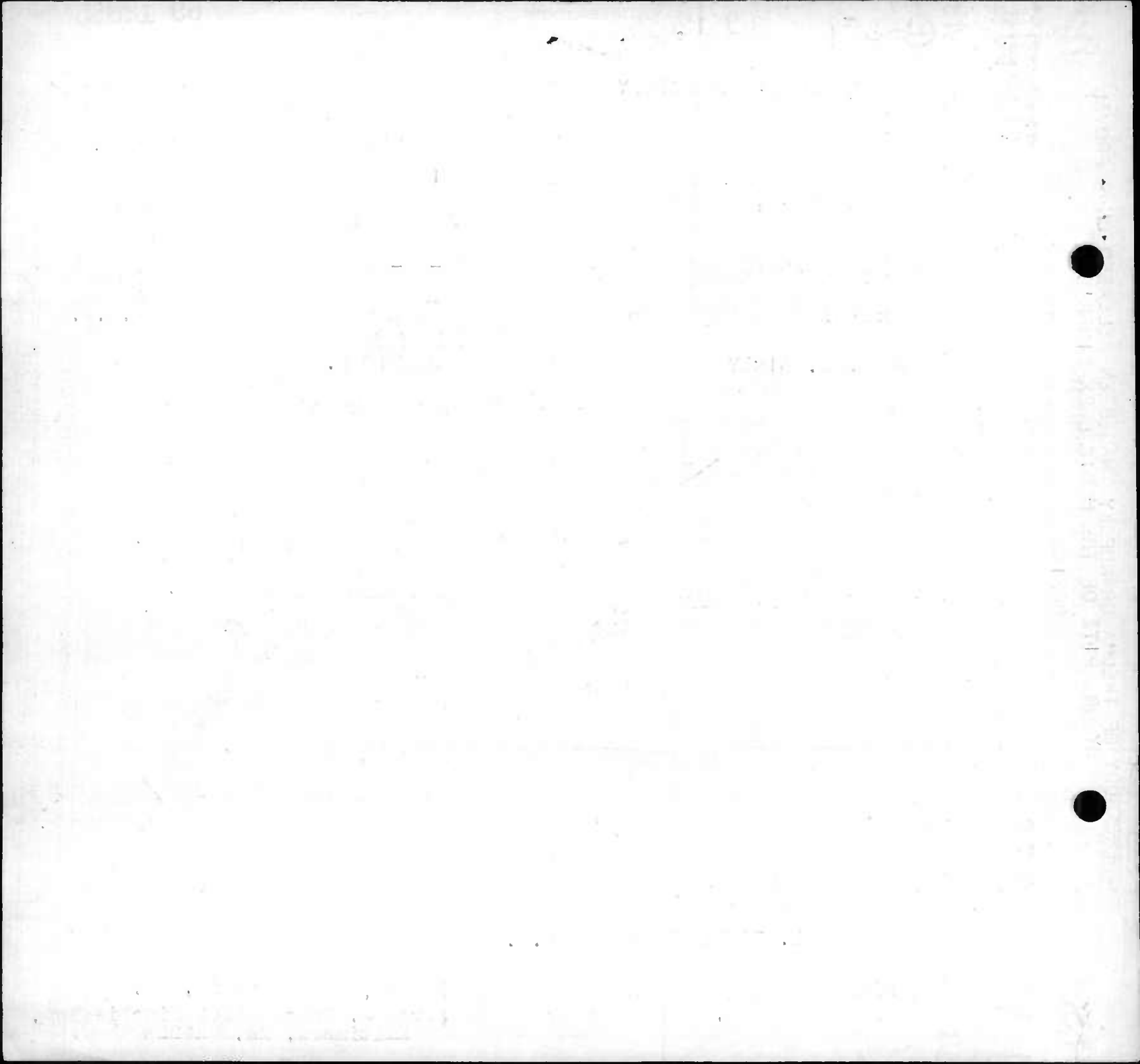
<div style="display: flex; justify-content: space-between;"> H-620 69 12054 BALTIMORE CITY HEALTH DEPARTMENT REG. NO. 69 12054 </div>	
BIRTH NO. 1	
1. NAME OF DECEASED (Type or Print) 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> Alice I. Harris 12-3-69 12:45 P.M. </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hosp 43	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <div style="display: flex; justify-content: space-between;"> Maryland 2544 </div>	
C. CITY OR TOWN D. INSIDE CITY LIMITS? <div style="display: flex; justify-content: space-between;"> Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> </div>	
E. STREET AND NUMBER 3710 - 4th Street	
5. SEX Female	6. RACE white
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-28-10
9. AGE (In years last birthday) 59	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
10B. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Mass. U.S.A.	
12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Charles MacDonald.	
14. MOTHER'S MAIDEN NAME Mable Fuller.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 220-384632	
17. INFORMANT ADDRESS Mrs. Ruth Zimmerman 515 4th Ave Gaithersburg, Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis Cardiovascular disease with congestive heart failure and myocardial infarct.	
(B) DUE TO, OR AS A CONSEQUENCE OF: and uremia	
(C) Bronchopneumonia	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (H) (this hospital) attended the deceased from 8:00p 11-28 19 69 to 2:45p 12-3 19 69, that (H) (we) last saw the deceased alive on 2:45p 12-3 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.	
23A. SIGNATURE 23B. DATE SIGNED <div style="display: flex; justify-content: space-between;"> <i>Hugh</i> 12-3-69 </div>	
23C. PHYSICIAN'S NAME (Type) 23D. ADDRESS <div style="display: flex; justify-content: space-between;"> DR H. CHAN. MD. S. Balt Gen Hosp. </div>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/5/69
24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial Pk.	24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR George J. Gonce
25C. FUNERAL DIRECTOR ADDRESS George J. Gonce 4001 Ritchie Hgy. Baltimore, Md. 21225	



THE BODY OF THELMA GRANOVSKY HAS BEEN RELEASED FOR APPROVAL
BY DR. SPIRITZ OF THE MEDICAL EXAMINER'S OFFICE

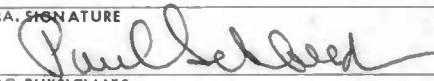
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-651		69 12055		BALTIMORE CITY HEALTH DEPARTMENT		69 12055	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
THELMA GRANOVSKY				12-1-69 9:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				MARYLAND		ANNE ARUNDEL 5200	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				RIVERA BEACH		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				8448 MAIN AVE			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
FEMALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		09-12-25	
						9. AGE (In years last birthday)	
						44	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Home		Maryland	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JAMES E. AIREY				Virginia			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT	
No				247-20-2019		Albert Granofsky	
						Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				DUE TO, OR AS A CONSEQUENCE OF:			
II				Epsia, Pneumonia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION OR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
3 12-1-69		Suspected Candida endocarditis		YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from 10/14 1969 to 12/1 1969, that (X) (we) last saw the deceased alive on 12/1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Paul L. Tecklenberg				12-1-69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
PAUL L. TECKLENBERG				M.D. 601 N. Broadway, Box 161, Baltimore, Md. 21205			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/5/69		Glen Haven Memorial Pk.		Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
		George J. Conce		4001 Ritchie Hgy. Baltimore, Md. 21225			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> H-520 69 12056 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 69 12056 </div>	
BIRTH NO. 1	
1. NAME OF DECEASED (Type or Print) 2. DATE AND HOUR OF DEATH	
JOSEPH HANUS DECEMBER 3, 1969 4:20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
2025 Maisel Street	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
Maryland	
C. CITY OR TOWN	
Baltimore	
D. INSIDE CITY LIMITS?	
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER	
2025 Maisel St.	
5. SEX	6. RACE
Male	White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 27, 1874
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
94	Farmer
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Germany	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
?	?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.
No	579 24 6002 A
17. INFORMANT	
Mr. Charles Hanus	
ADDRESS	
Same	
18. CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: AC.U.D (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED
0	
20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
No	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21D. TIME OF INJURY (APPROX.)
	(Month) (Day) (Year) (Hour)
21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from Jan 12 1950 to Mar 3 1969, that (I) (we) last saw the deceased alive on Dec 3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE	23B. DATE SIGNED
	12/3/69
23C. PHYSICIAN'S NAME (Type)	23D. ADDRESS
Dr. Paul Schoenfeld	2301 Annapolis Rd. Baltimore, Md.
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE
Burial	12/6/69
24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Holy Redeemer	Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR
12/6/69	George J. Gonce
25C. FUNERAL DIRECTOR	25D. ADDRESS
George J. Gonce	4001 Ritchie Hgy. Baltimore, Md. 21225

AGD

East of point

recovered

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12057	
C-452 69 12057 CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) George H. Collins			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 122 E. Randall St.		2. DATE AND HOUR OF DEATH Dec. 5, 1969 5 A. M.			
5. SEX Male		6. RACE White		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2404	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1894 Dec. 26, 1904		9. AGE (In years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Dairy Supplies		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME Daniel Collins			
14. MOTHER'S MAIDEN NAME Adelaide Reed		15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 216 03 9709 A		17. INFORMANT Mrs. Lola A. Collins ADDRESS 122 E. Randall St.			
CERTIFICATE AMENDED-12/5/69					
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CARCINOMA - RIGHT LUNG					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (1) PROSTATIC HYPERTROPHY WITH URINARY RETENTION (2) ARTERIOSCLEROTIC HEART DISEASE (3) SECONDARY ANGINA					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION No		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 13, 1962 to Dec 5, 1969 that (I) (we) last saw the deceased alive on Nov. 30, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE H.P. Friedman M.D.				23B. DATE SIGNED 12/5/69	
23C. PHYSICIAN'S NAME (Type) H.P. FRIEDMAN M.D.				23D. ADDRESS 1319 LIGHT ST. BALT. MD. 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 8 69		24C. NAME OF CEMETERY or CREMATORY Prospect	
24D. LOCATION (City, town, or county) (State) Mount Airy, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969			
25B. FUNDING DIRECTOR Mc Cully				25C. ADDRESS 130 E. Fort Ave	

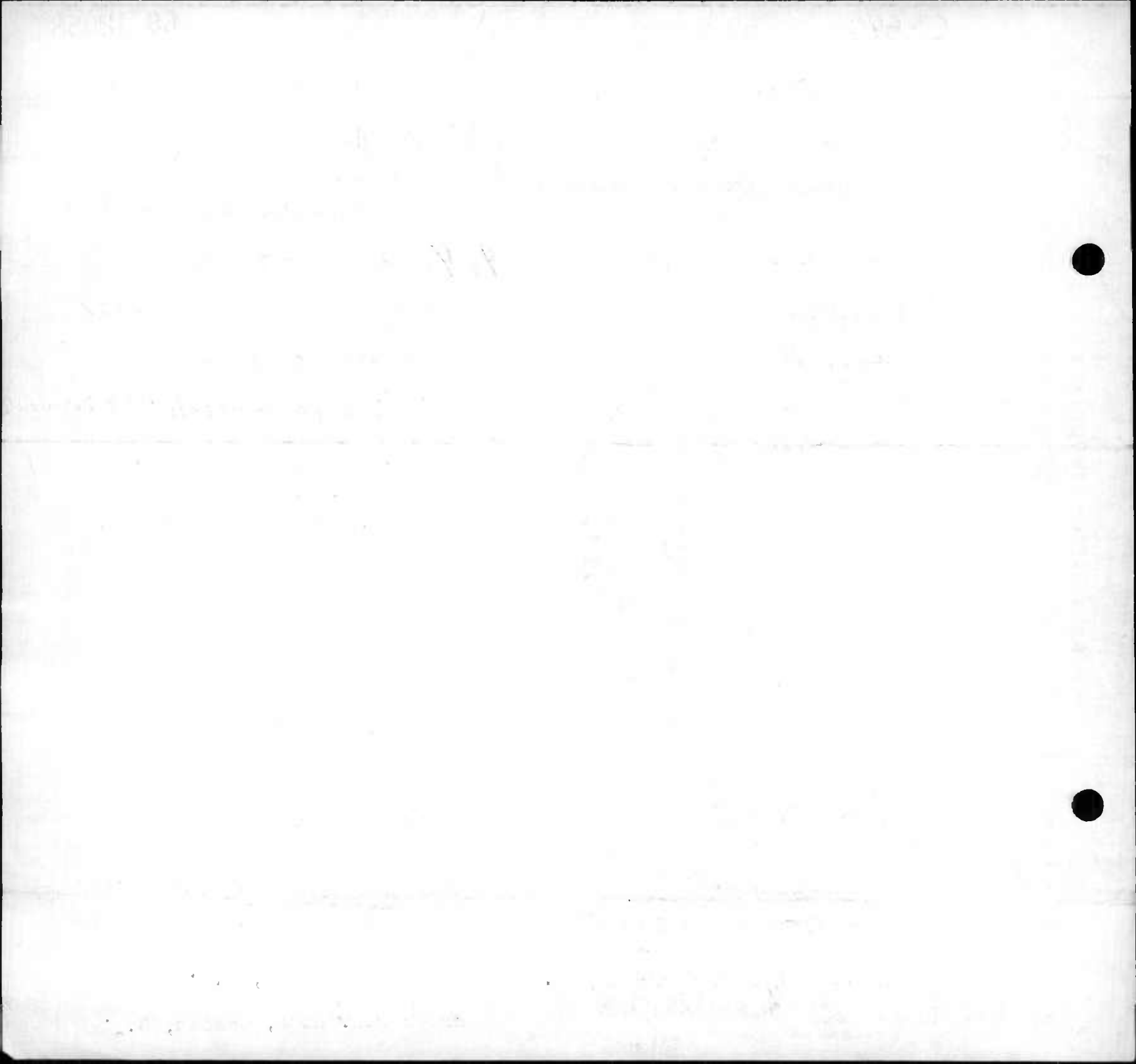
12/15/69 - Birth certificate. B-1863. Date of birth: 12/26/1894.

ABC.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

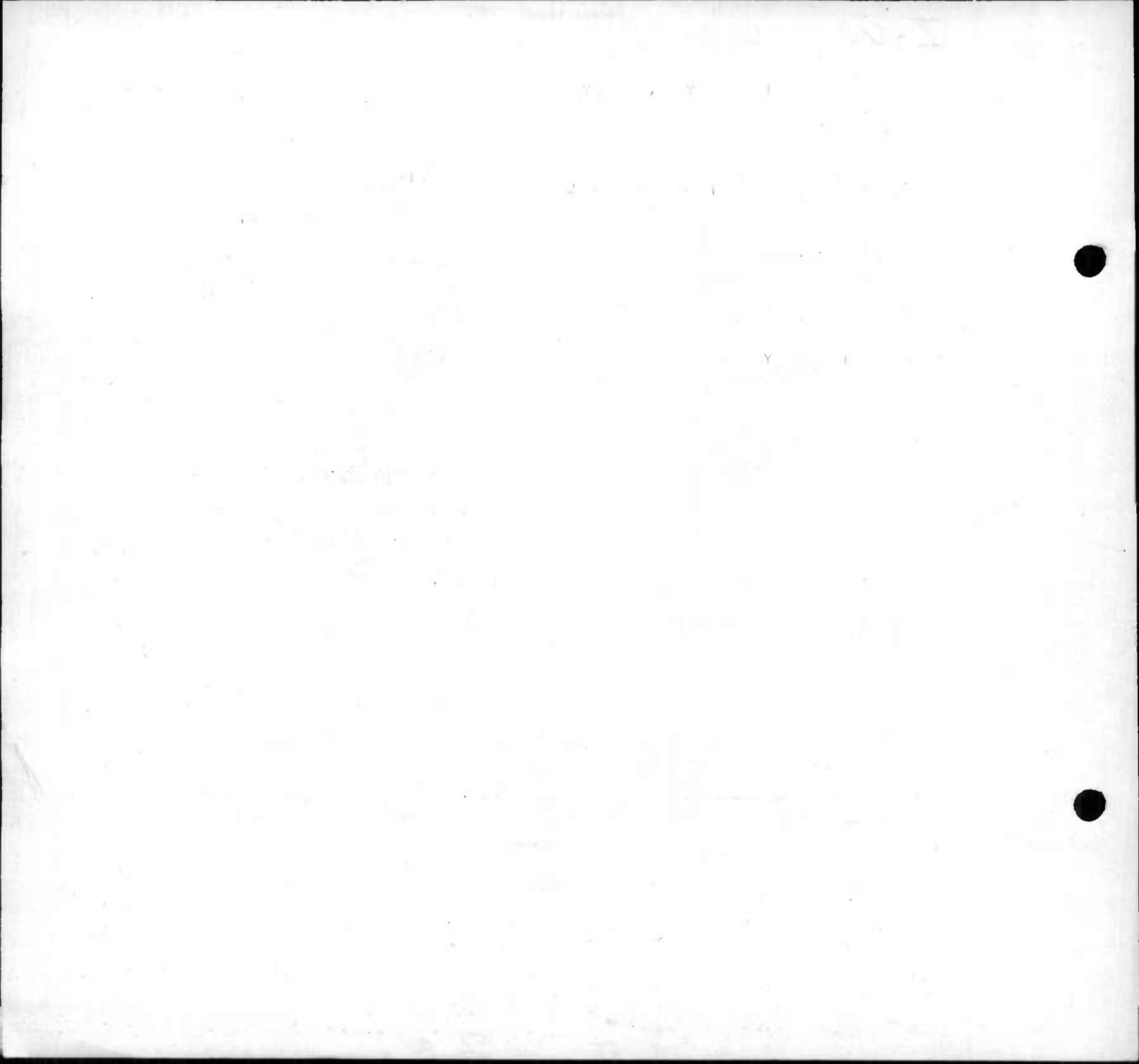
69 12058 CERTIFICATE OF DEATH		Registered No. 69 12058	
BIRTH NO. 0-640 M.E. CASE NO.		2. DATE AND HOUR OF DEATH 11-17-69 8:45 a.m.	
1. NAME OF DECEASED (Type or Print) JAMES Carroll		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1302	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 705 Newington Ave Balb. md.	
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9/9/12
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed		10B. KIND OF BUSINESS OR INDUSTRY -	9. AGE (In years last birthday) 57
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ben Carroll		14. MOTHER'S MAIDEN NAME Joseph, E. NICE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO. 513-19376	17. INFORMANT San Joseph Carroll ADDRESS 738 Reservoir
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY ARREST Smoke Inhalation Burns to thorax + head		CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH 2 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION 0 -		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -	
20A. AUTOPSY? (Yes or No) -		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
21C. WHERE DID INJURY OCCUR? 705 Newington St. 1302		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 11-15-69	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fire	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from 11-15 19 69 to 11-17 19 69 , that (I) <u>(we)</u> lost saw the deceased alive on 11-17- 19 69 and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> (did) (did not) view the body after death.			
23A. SIGNATURE Stanley Silber		23B. DATE SIGNED 11-17-69	
23C. PHYSICIAN'S NAME (Type) STANLEY SILBER		23D. ADDRESS MARYLAND GENERAL HOSP	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11/25/69	
24C. NAME OF CEMETERY or CREMATORY Union Bap. Church		24D. LOCATION (City, town, or county) (State) Rembert, S.C.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR John E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Brown Fun. Home, Camden, S.C.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

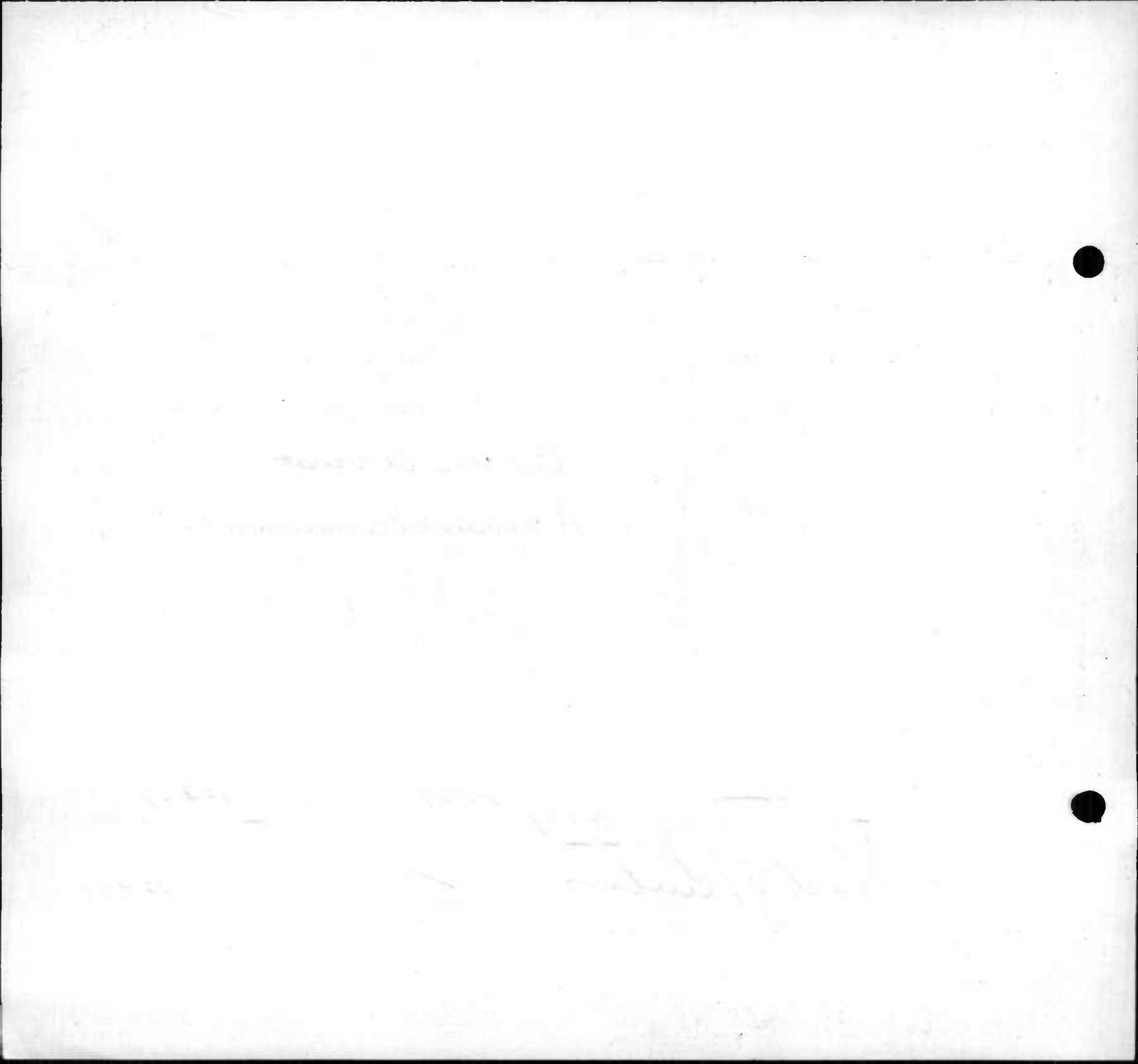
I-60 69 12059				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12059	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) KINGSLEY E. IRBY				2. DATE AND HOUR OF DEATH 12-4-69 7:35 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 807 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1711 ELLSWORTH ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-1-05		9. AGE (In years, last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BAR TENDER			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VA		
13. FATHER'S NAME CHARLIE IRBY			14. MOTHER'S MAIDEN NAME IDA				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARY IRBY 1711 ELLSWORTH ST		
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Coronary Vascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atrial Fibrillation HAS CVD				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) None APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 72 hours			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). None							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 3, 1969 to Dec 4, 1969 , that (I) (was) last saw the deceased alive on Dec 4, 1969 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Richard G. Bensinger MD				23B. DATE SIGNED Dec 4, 1969		23C. PHYSICIAN'S NAME (Type) RICHARD BENINGER MD	
23D. ADDRESS JOHNS HOPKINS HOSPITAL				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12/9/69		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) D.A. County Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969	
25B. NAME OF REGISTRAR Joseph B. Locks		25C. FUNERAL DIRECTOR 1304 N. Central Ave		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

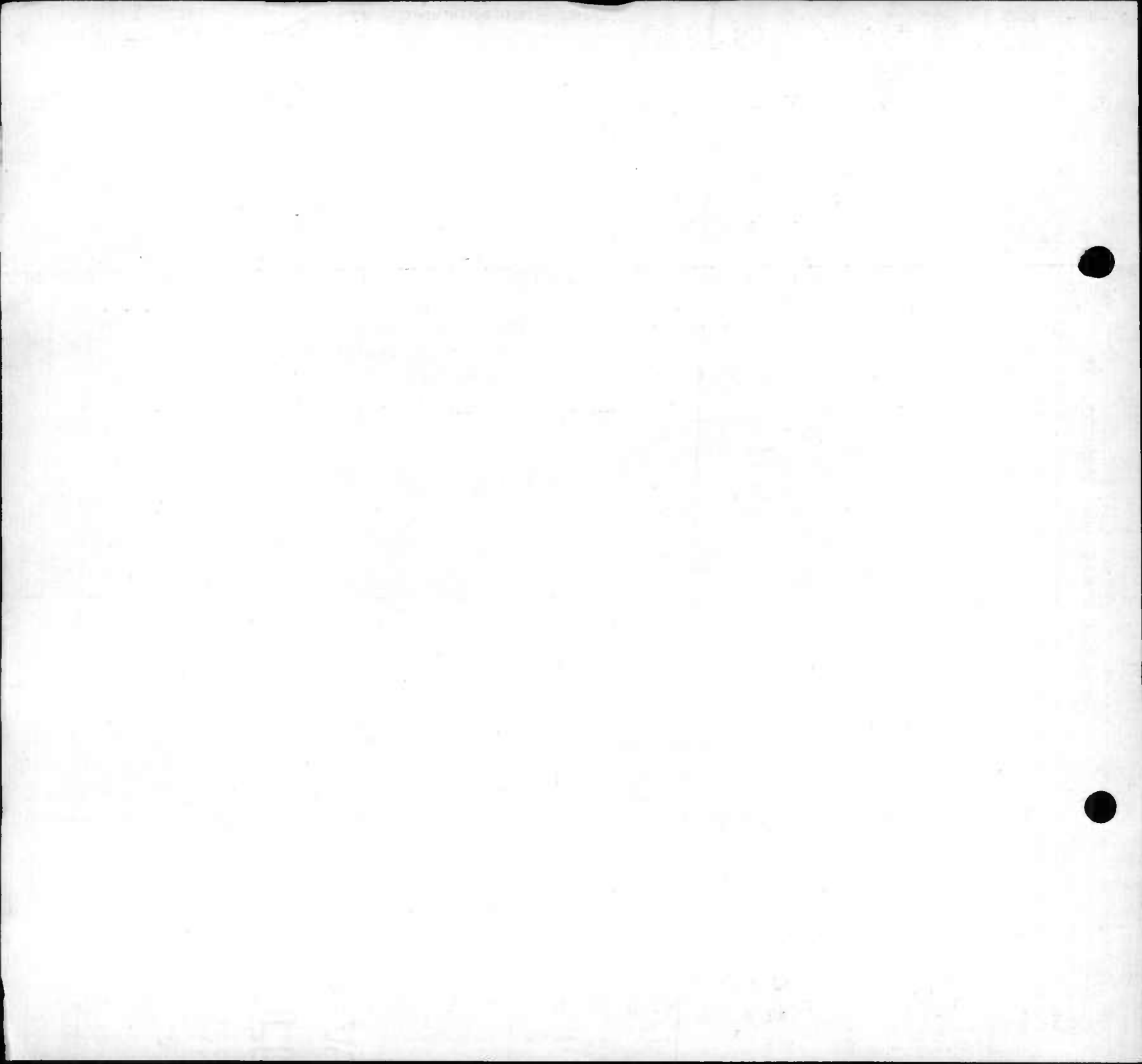
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12060
BIRTH NO. 1. NAME OF DECEASED (Type or Print) John H. Watson		2. DATE AND HOUR OF DEATH <div style="text-align: right;">Dec. 3, 1969</div> <div style="text-align: right;">M.</div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <div style="font-size: 2em; float: left; margin-right: 10px;">90</div> Pleasant Manor Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2748 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1357 Sherwood Ave.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 18, 1898	9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AGENT		10B. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) BRITISH West Indies
13. FATHER'S NAME Norton B. Watson		14. MOTHER'S MAIDEN NAME Marie L. Deane		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 086-14-1415		17. INFORMANT ADDRESS Robert N. Watson, 1357 Sherwood Ave,
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Antecedent cardiovascular disease yr. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9-5-69 to 12-3-69, that (I) lost saw the deceased alive on 12-1-69 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (do) (did not) view the body after death.				
23A. SIGNATURE 				23B. DATE SIGNED 12-4-69
23C. PHYSICIAN'S NAME (Type) Frank G. Kuehn, M.D.		23D. ADDRESS Medical Arts Building		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/69		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park
24D. LOCATION (City, town, or county) (State) Parkville, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		
25B. NAME OF REGISTRAR E. J. J.		25C. FUNERAL DIRECTOR ADDRESS Ullrich Funeral Home 4210 Belair Road.		



FUNERAL DIRECTOR: IMPORTANT

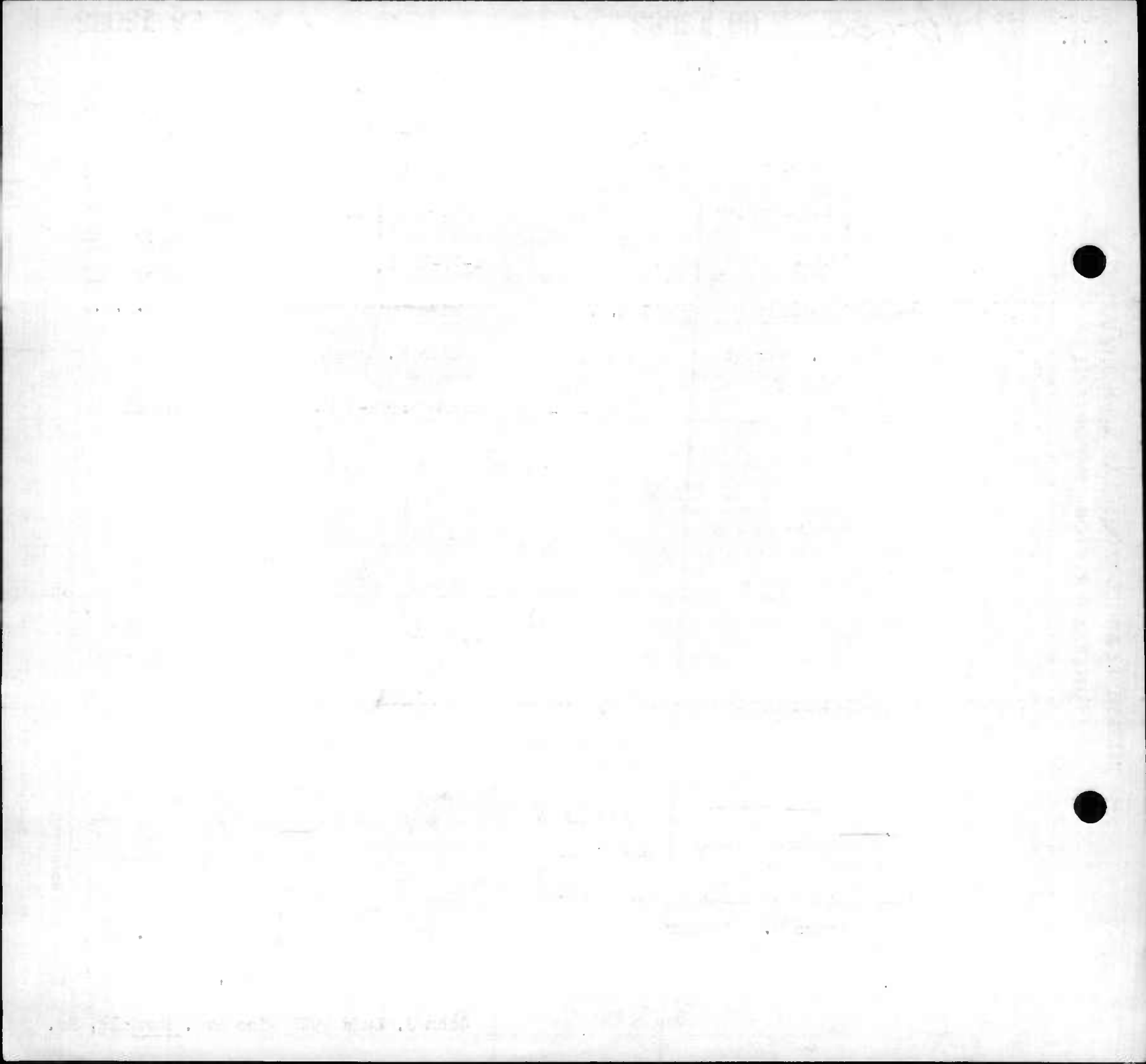
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-520		69 12061		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12061	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Margaret F. Fink			
2. DATE AND HOUR OF DEATH 12/2/69 5:40 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITALS 4940 EASTERN AVE. BALTO. MD. 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2646 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6132 Bessmer Ave. 21224 007			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-23-93	
9. AGE (In years last birthday) 76		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Swartz		14. MOTHER'S MAIDEN NAME Mollie Graley		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 223-24-0566JI		17. INFORMANT BCH Records; 4940 Eastern Ave. 21224		ADDRESS		18. 422.91 CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CVA				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Cardiac Arrhythmia			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (He) (this hospital) attended the deceased from 11/18/69 to 12/2/69, that (He) (we) last saw the deceased alive on 12/2/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J R Neefe MD				23B. DATE SIGNED 12/2/69		23C. PHYSICIAN'S NAME (Type) J. R. Neefe, M.D.	
23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. 21224				23E. NAME OF REGISTRAR Ulrich E. Saylor, M.D.		23F. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/4/69		24C. NAME OF CEMETERY or CREMATORY Mt. Carmel		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Ulrich E. Saylor, M.D.		25C. FUNERAL DIRECTOR Ulrich Funeral Home Dundalk, Md.		ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

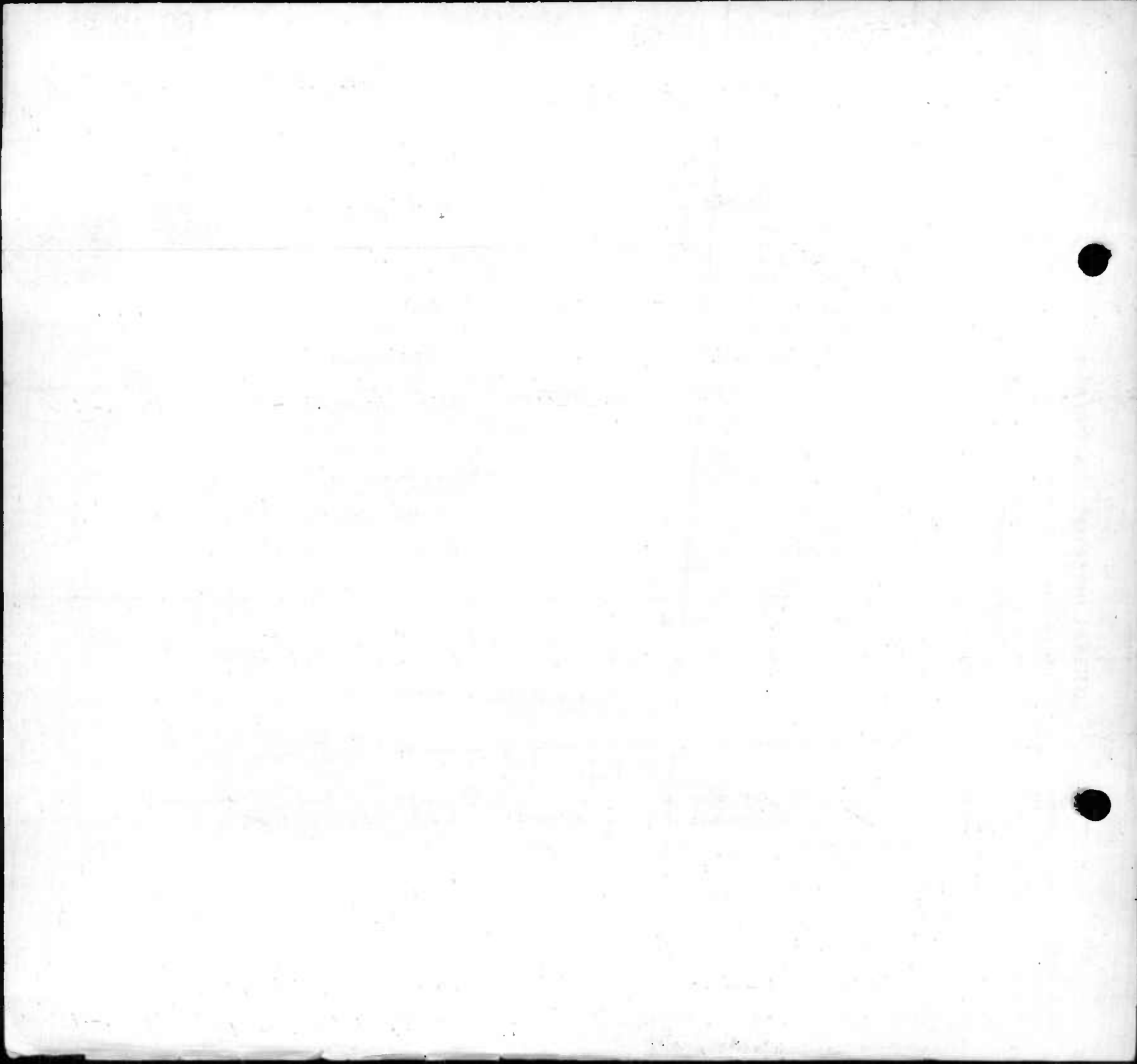
B-630		69 12062		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12062	
BIRTH NO.		E.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
		ROY BARRETT				12-2-69		11:20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE		B. COUNTY			
		Maryland		Baltimore		53-00			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
31		Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		Dundalk		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER		202 Woodwell Road		21222					
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-17-1902	67	Train Dispatcher		B & O R.R.		Wisconsin
12. CITIZEN OF WHAT COUNTRY?		U.S.A.		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
		Wilson H. Barrett		Ella M. Treet		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		705-09-0042		17. INFORMANT		ADDRESS			
		Records: BCH-4940 Eastern Avenue 21224							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Diabetes Mellitus							
II		ASCVD							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Sept 8, 1969 to present, that (I) (we) last saw the deceased alive on 11-28, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED					
Bruce M. Bucher		12-2-69							
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR		ADDRESS			
Bruce M. Bucher		Baltimore City Hospitals 4940 Eastern Avenue, Baltimore, Md. 21224		John J. Duda		7922 Wise Ave. Dundalk, Md. 21222			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		12/6/69		Oak Lawn		Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 8 1969		John J. Duda		John J. Duda		7922 Wise Ave. Dundalk, Md. 21222			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

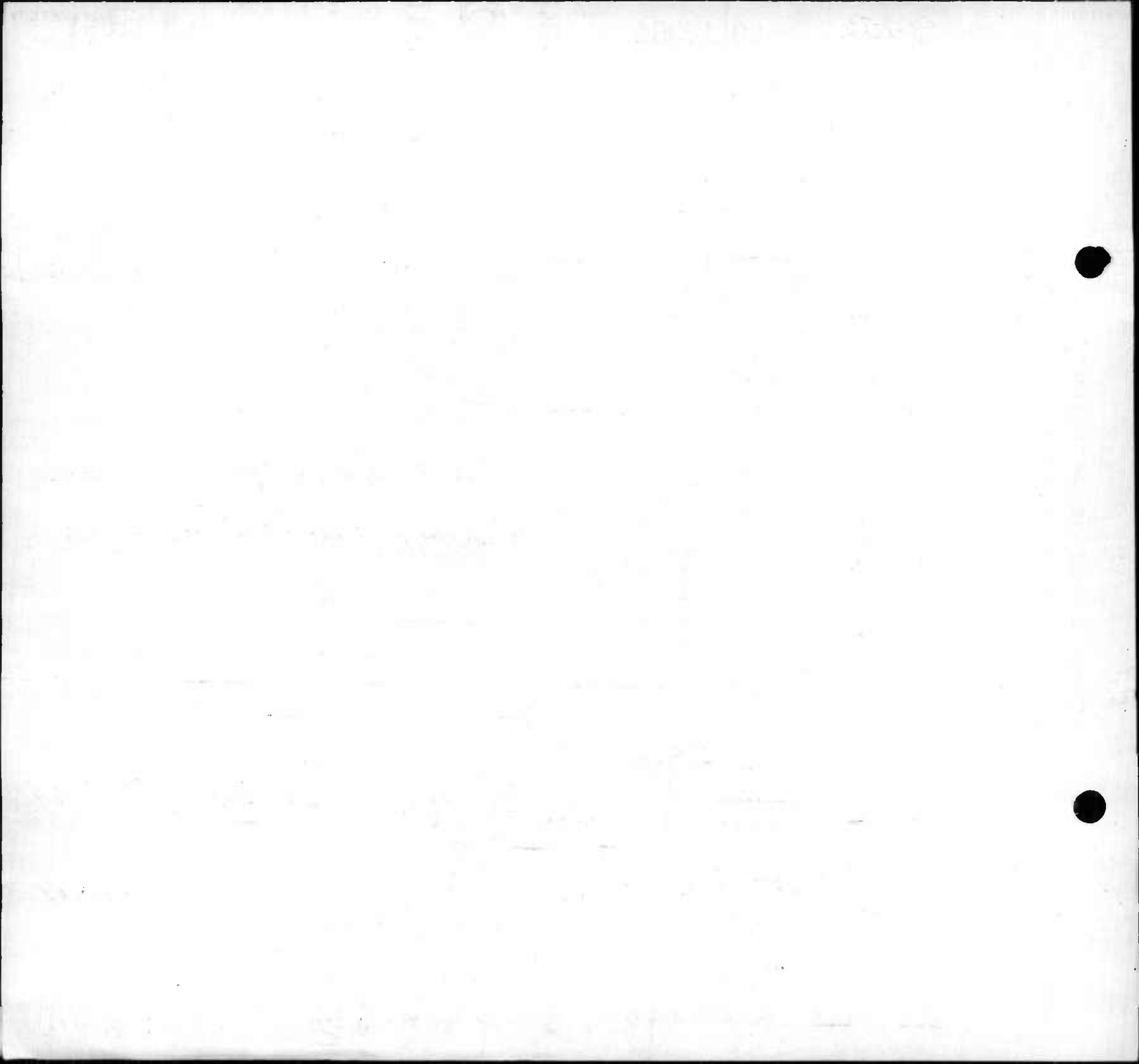
C-5/2		69 12063		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12063	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Vincent Ciampaglia				Dec. 2, 1969 7 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 5580 Belair Road				Maryland 2734			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				5580 Belair Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. If Under 24 Hrs. Min.
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	January 29, 1889	80			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Shoe Maker				Self-Employed		Italy	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
Frank Ciampaglia				U.S.A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				220-30-1196		Alice Ciampaglia - 5580 Belair Rd. - 21206	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				Hypertensive arteriosclerotic Cardio-vascular disease			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Pulmonary fibrosis and emphysema			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No		1 yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 25 November 1968 to 2 December 1969, that (I) (we) last saw the deceased alive on 3 November 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John W. Barnaby				2 Dec 69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN W. BARNABY				1652 E Belvedere Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-4-69		Holy Redeemer Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 8 1969		John C. Miller Inc.		John C. Miller Inc-6415		Belair Rd. - 21206	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-152		69 12064		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12064	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Maria A. Siebenkittel			
2. DATE AND HOUR OF DEATH Dec. 6, 1969				Early 9:00 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 711 Benninghaus Road Baltimore, Md. 21212				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, 21212 B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 711 Benninghaus Road			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1880	9. AGE (In years last birthday) 89	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker			10B. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? No
13. FATHER'S NAME Alois Fritsch			14. MOTHER'S MAIDEN NAME Agnes Wilsch				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-54-7808		17. INFORMANT Eleonora Medaugh (Daughter) Same		ADDRESS
18. 43801 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Acute Right Hemiplegia Antecedent Causes Arterial Hypertension & arteriosclerosis DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 2 years			
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Nat White At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from Jan 20, 1967 to Dec 6, 1969 , that (I) (was) last saw the deceased alive on Dec 5, 1969 and that in (my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.							
23A. SIGNATURE M. B. Levin				23B. DATE SIGNED Dec 6, 1969		23C. PHYSICIAN'S NAME (Type) Dr. M. B. Levin	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/8/1969		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969				25B. NAME OF REGISTRAR James E. Kelly		25C. FUNERAL DIRECTOR Eugene A. Stitz	
26A. ADDRESS 5209 York Rd.				26B. ADDRESS Stitz Funeral Home Baltimore, Md. 21212			



W-256

69 12065

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 12065

BIRTH NO. <u>W-256</u>		69 12065	
1. NAME OF DECEASED (Type or Print) <u>WAGNER, CHARLES</u>		2. DATE AND HOUR OF DEATH <u>12-3-69 4:25 AM</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>908</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospital</u> <u>1940 Eastern Avenue, Baltimore, Md. 21224</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>505 E 26TH ST. 21218</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 30, 1888</u>
9. AGE (In years last birthday) <u>81</u>		10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Accounting</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records: BCH-4940 Eastern Avenue 21224</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <u>30% 3rd DEGREE BURNS.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH <u>30% 3rd DEGREE BURNS.</u> IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>505 E 26th St 21218</u>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12/3/69 4:25 AM</u>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Thought to have fallen asleep.</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/1/69</u> to <u>12/3/69</u> and that (I) (we) last saw the deceased alive on <u>12/3/69</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>12/3/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>ENRIQUE CASTRO</u>		23D. ADDRESS <u>BALTIMORE CITY HOSPITALS</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/8/69</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1969</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>	
25C. FUNERAL DIRECTOR <u>Union Funeral Home, 4210 Belair Road.</u>		ADDRESS	

RELEASED ON APPROVAL BY MEDICAL EXAMINER
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Handwritten signature

12 1 21
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H-620

69 12066

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12066

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIAM L. HIRSCH				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3438 Mt. Pleasant Avenue (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour December 2, 1969 11:50 P.			
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2608	
9. DATE OF BIRTH 11/12/'05		10. AGE (In years lost birthday) 64		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ?		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Leader		15. MOTHER'S MAIDEN NAME Mary Ann Vogel		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 216-07-3230		18. INFORMANT Mrs. Rena Hirsch		19. CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease		20. DATE OF OPERATION 2	
21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Craniocerebral Injuries		22. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		23. WHERE DID INJURY OCCUR? 3438 Mt. Pleasant Avenue		24. HOW DID INJURY OCCUR? Found by wife at bottom of stairs	
25. TIME (Month) (Day) (Year) (Hour) (Approx.) 12-2-69 7:00P. 11:15P.		26. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		27. DATE OF OPERATION 2		28. CONDITION FOR WHICH OPERATION WAS PERFORMED	
29. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		30. DATE OF OPERATION 2		31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY? (Yes or No) yes	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				24. DATE OF OPERATION 2			
25. ACTUAL SIGNATURE Ronald N. Kornblum, M.D.				26. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
27. DATE SIGNED 12/3/69				28. DATE OF OPERATION 2			
29. BURIAL CREMATION, REMOVAL (Specify) Burial		30. DATE 12/6/'69		31. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		32. LOCATION (City, town, or county) (State) Baltimore, Md.	
33. DATE REC'D BY HEALTH DEPT. DEC 8 1969		34. NAME OF REGISTRAR John E. Kelly, R.D.		35. FUNERAL DIRECTOR John A. Moran, Inc.		36. ADDRESS 3000 E. Baltimore St.	

Paul M. Hall

L-235

69 12067

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12067

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) MILDRED E. LIGHTNING (Mildred Lightning)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 2 69 6:45 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 38 University Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 2 69 6:45 a.m.	
6. SEX female		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Mar. 20, 1926		10. AGE (In years last birthday) 43	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward S. Johnston		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	
15. MOTHER'S MAIDEN NAME Ethel E. Everly		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. NONE		18. INFORMANT Ethel E. Johnston: 120 S. Haven St., Balto., Md.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Chronic alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) house	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 120 S. Haven St. 2608		22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 11 1 69 6:30 p.m.	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? presumably fell from steps	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/2/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-5-69	
24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) 2901 Taylor Ave. Balto. Co., Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Charles E. Spitzer	
25C. FUNERAL DIRECTOR Charles E. Spitzer		25D. ADDRESS 901 Conkling St. Balto., 21224, Md.	

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RECEIVED BY THE POST OFFICE

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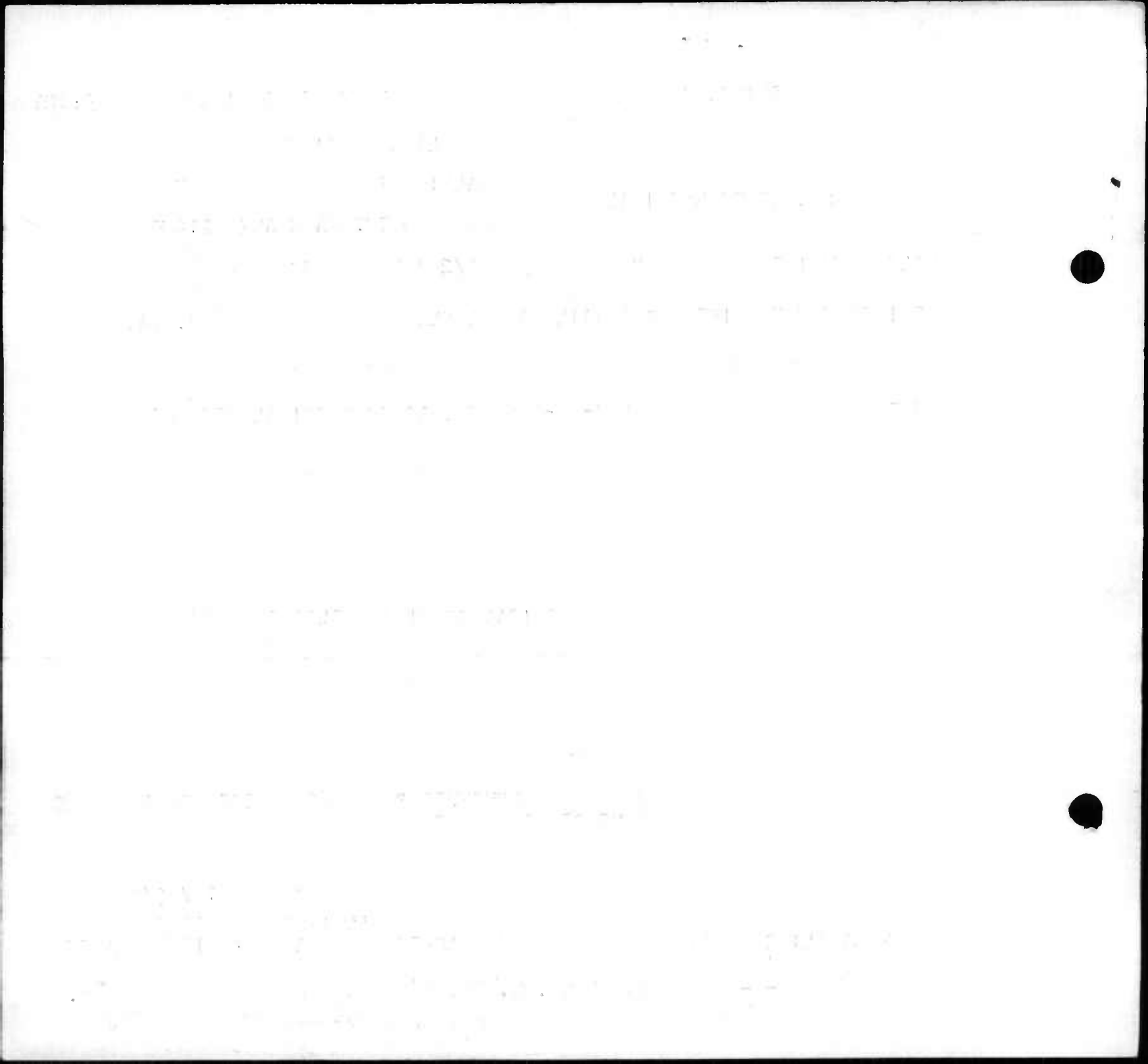
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

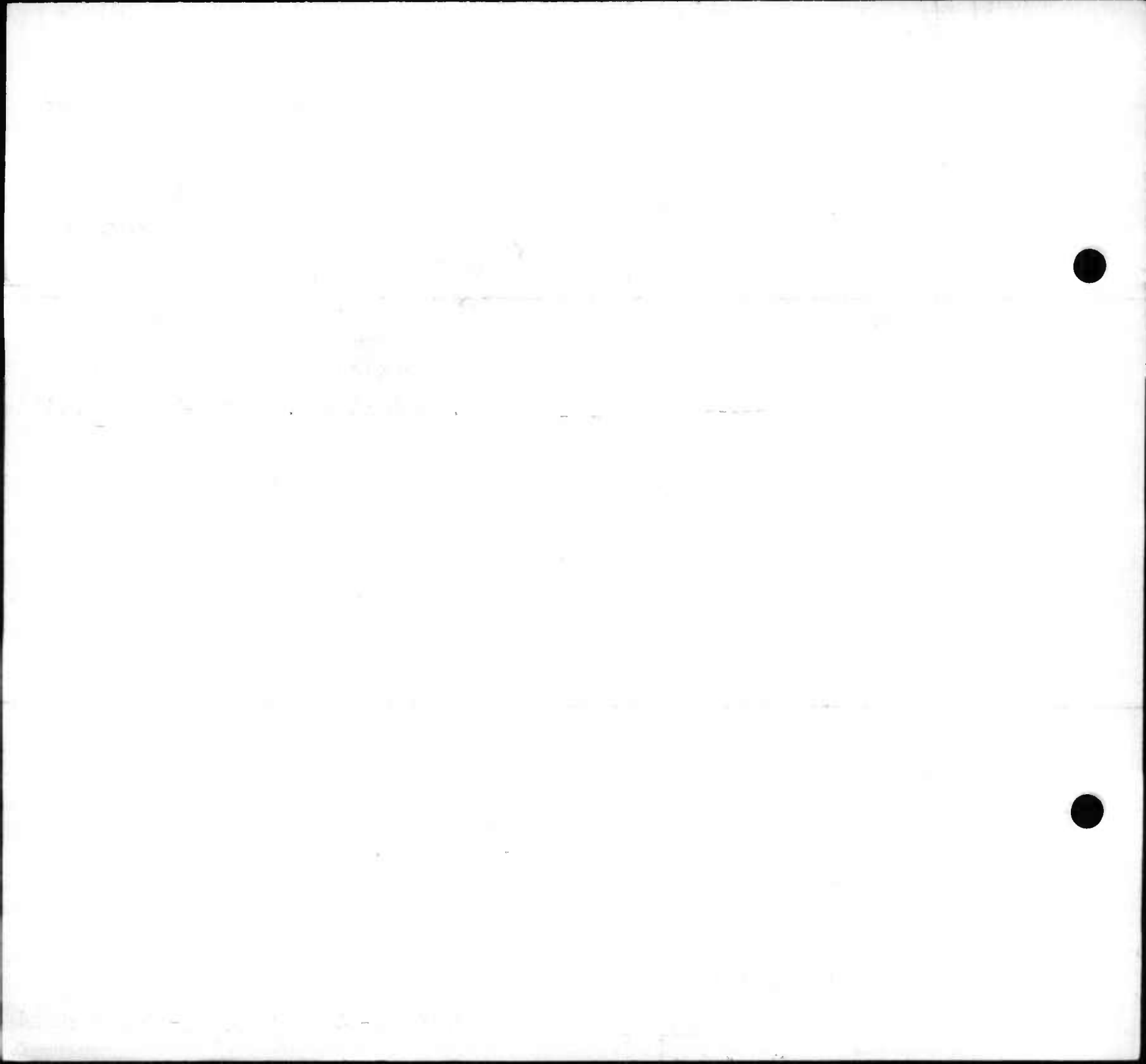
D-652		69 12068		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12068		
BIRTH NO.				1. NAME OF DECEASED (Type or Print)				
				DEERING, JOHN M				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)				
40 ST. AGNES HOSPITAL				A. STATE MARYLAND CITY 2833				
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER 1800 FOREST PARK AVE 21207				
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01/2/84	9. AGE (In years last birthday) 85	10. If Under 1 Yr. Months Days			11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
RETIRED TRUCK DRIVER B & O RAILROAD						MARYLAND		
13. FATHER'S NAME August Deering				12. CITIZEN OF WHAT COUNTRY? U.S.A.				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. 705-09-2964		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				
ANTECEDENT CAUSES				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASES OR CONDITIONS, if any, which rise to the above cause (All stating the UNDERLYING CONDITION last.)				IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: TERMINAL PNEUMONIA				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE IMMEDIATE DISEASE OR CONDITION GIVEN IN PART 1 (A)				DUE TO, OR AS A CONSEQUENCE OF: ASCVD				
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED DEBRIDEMENT OF EX		20A. AUTOPSY? (Yes or No) NO		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Approx.)				21E. INJURY OCCURRED		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 30 1969 to DECEMBER 3 1969 that (I) (we) last saw the deceased alive on NOVEMBER 3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.								
23A. SIGNATURE M. Cabiling				23B. DATE SIGNED 12/03/69		23C. PHYSICIAN'S NAME (Type) M CABILING, M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-5-1969		24C. NAME OF CEMETERY OR CREMATORY Salem Luth. Ch. Cemetery		
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		
				24D. LOCATION (City, town, or county) Catonsville		24D. LOCATION (State) Md.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

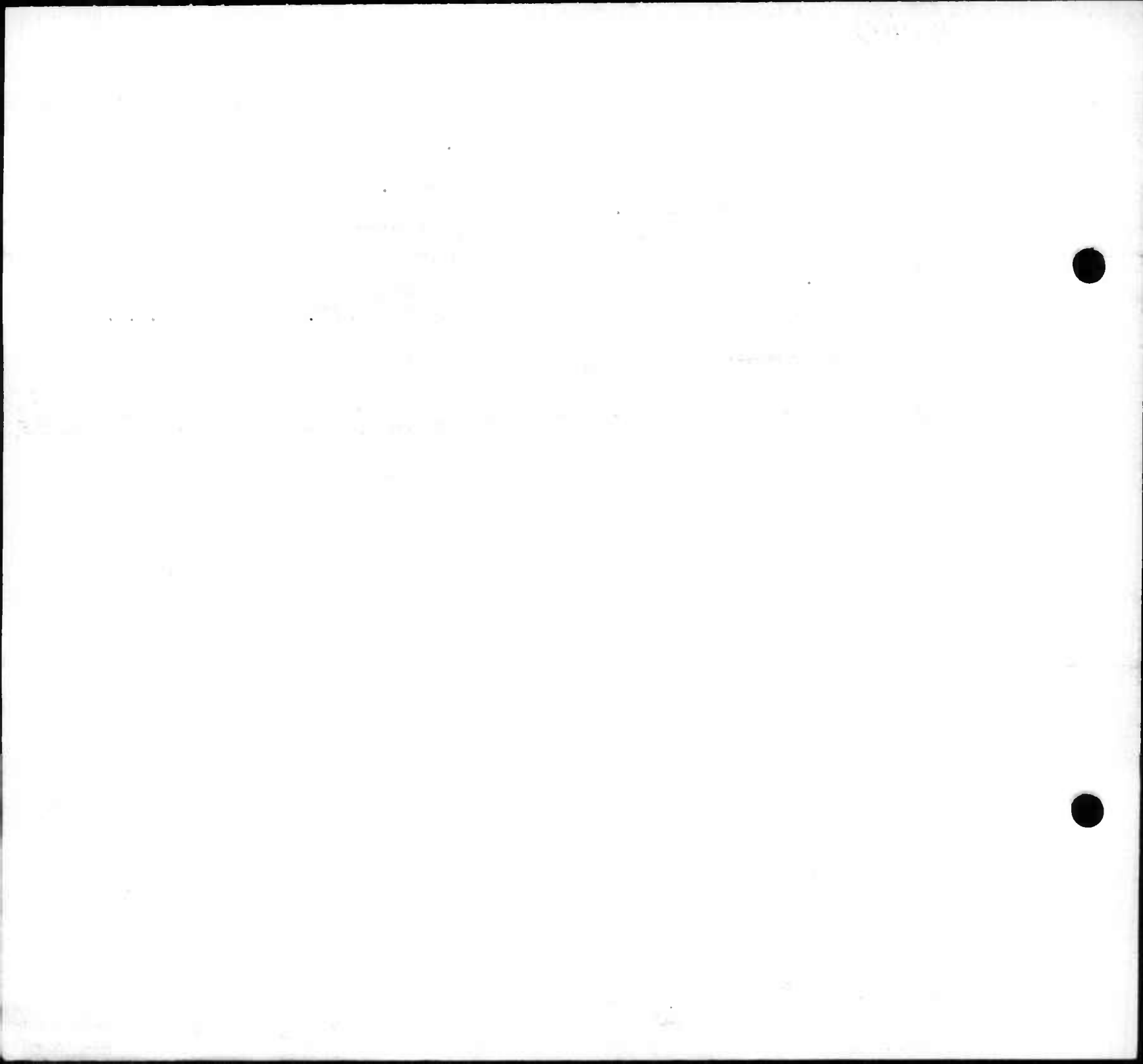
B-652		69 12069		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12069	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>JOHANN V BRUNS</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MERCY Hospital</u>				2. DATE AND HOUR OF DEATH <u>12/2/69</u> <u>4:00</u> A.M.			
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MD</u> B. COUNTY <u>908</u>				C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>636 Cokesbury Ave</u>							
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-9-17</u>	9. AGE (In years last birthday) <u>52</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COMPANION - HOME MAKER -</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO - MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>JOHN BRUNS</u>			
14. MOTHER'S MAIDEN NAME <u>MARIE FREDERICK.</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>216-18-9654</u>				17. INFORMANT <u>Mrs. Catherine S. Clarke-10 Kirk Hill Court-28</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio respiratory failure</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma of left breast with metastases to liver, lungs and brain</u> Over a year.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>-</u>							
19A. DATE OF OPERATION <u>-</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>-</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? <u>-</u> (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>11. 26. 19 69</u> to <u>12. 2. 19 69</u> that (I) (we) last saw the deceased alive on <u>12. 1. 19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ranbir P. Sinha M.D.</u>				23B. DATE SIGNED <u>12. 2. 69.</u>			
23C. PHYSICIAN'S NAME (Type) <u>RANDHIR PRASAD SINHA M.D.</u>				23D. ADDRESS <u>MERCY HOSPITAL, Balt. Md. 21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/5/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cathedral Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mitchell Medefield</u>		ADDRESS <u>Home-6500 York Rd 21212</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

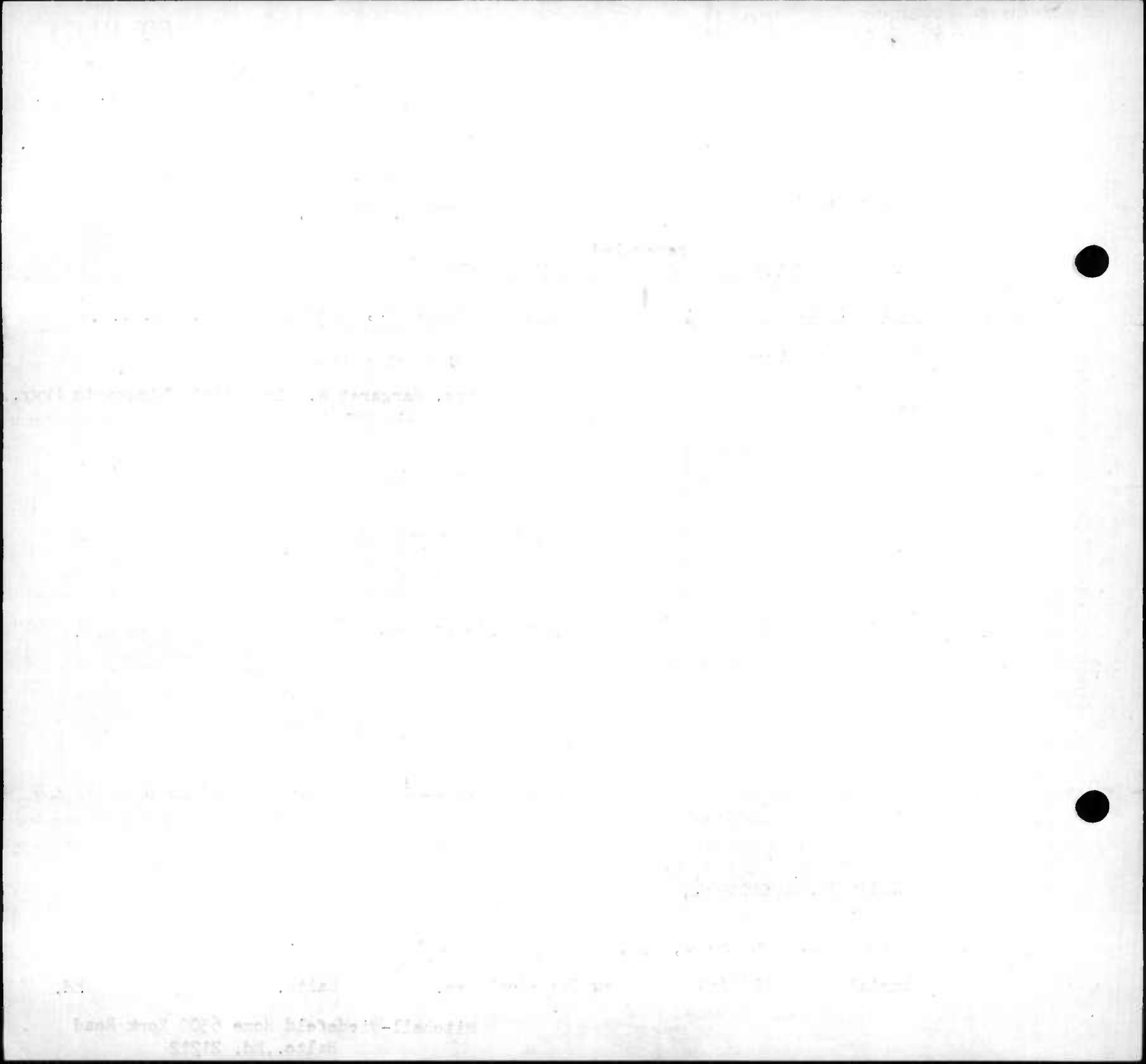
D-400		69 12070		BALTIMORE CITY HEALTH DEPARTMENT		69 12070	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Anna M. Duley</u>				2. DATE AND HOUR OF DEATH <u>December 3, 1969</u> <u>7:05</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 Mercy Hospital, Inc.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2633</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3106 Pelham Ave</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/8/08</u>	9. AGE (In years last birthday) <u>61</u>	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housemaker</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>George XXXXXX AHERS BACH</u>			14. MOTHER'S MAIDEN NAME <u>Bertha Jones</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. Melvin R. Duley</u>		ADDRESS <u>3106 Pelham Ave</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Brain damage</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Tumor of Brain</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>6 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Dehydration, cachexia</u>							
19A. DATE OF OPERATION <u>MAY 1969</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Brain Tumor</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/1/69</u> to <u>12/3/69</u> that (I) (we) last saw the deceased alive on <u>12/3/69</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>H. C. KARAS</u>				23B. DATE SIGNED <u>12/3/69</u>			
23C. PHYSICIAN'S NAME (Type) <u>H. C. KARAS</u>				23D. ADDRESS <u>MERCY HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12/6/69</u>		24C. NAME of CEMETERY or CREMATORY <u>MORELAND MEM</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO - MD.</u>	
25A. DATE RECD. BY HEALTH DEPT. <u>DEC 8 1969</u>		25B. NAME OF REGISTRAR <u>WITCHETT</u>		25C. FUNERAL DIRECTOR <u>WIEDEFELD HOME</u>		ADDRESS <u>6500 YORK RD. BALTO MD.</u>	



FUNERAL DIRECTOR: IMPORTANT

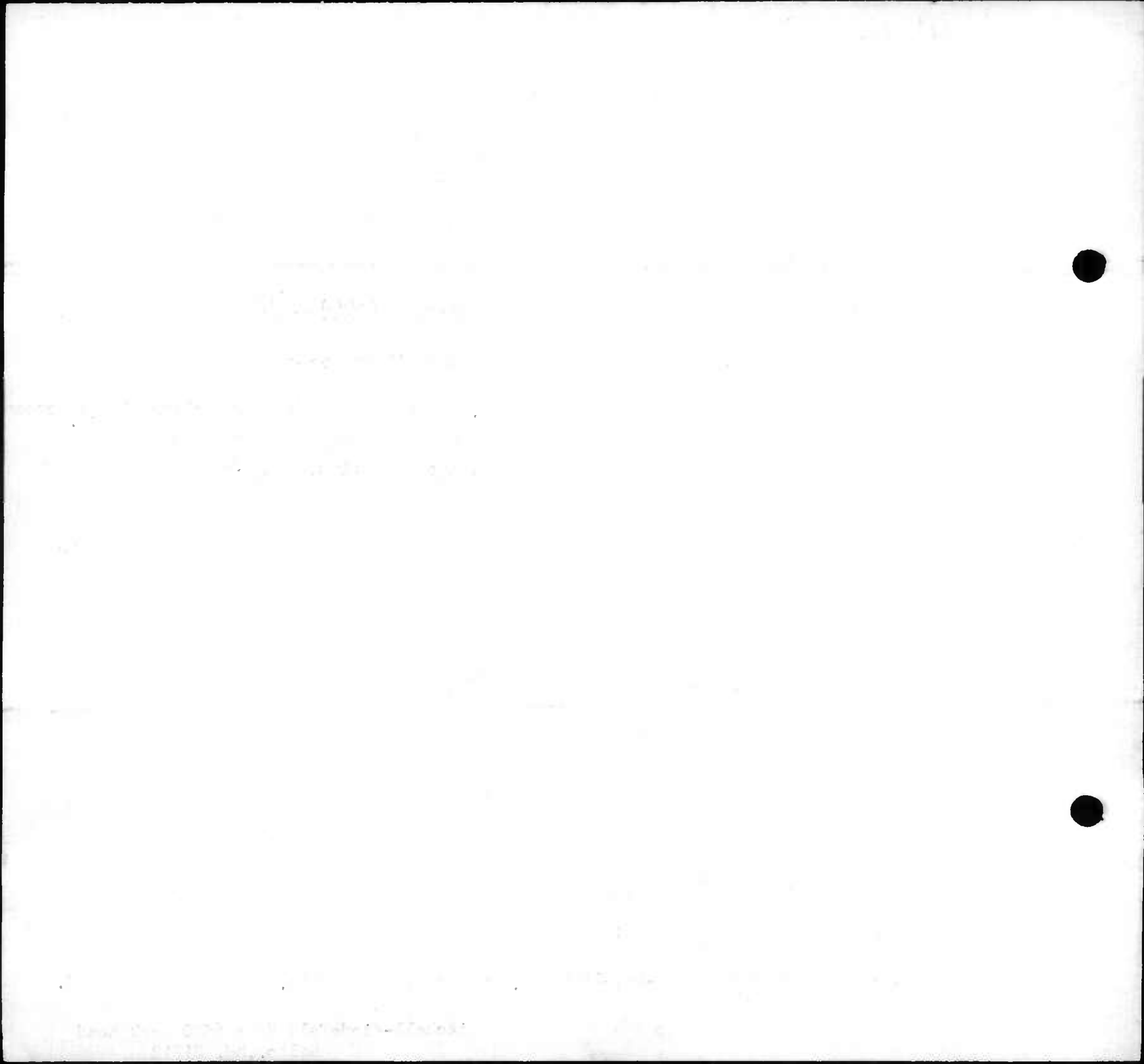
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>69 12071</u>
BIRTH NO. <u>K-610</u>		69 12071		
1. NAME OF DECEASED (Type or Print) Harry Kirby		2. DATE AND HOUR OF DEATH 12-2-69 3:10 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 91 Keswick Home Sep.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1307 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 700 W. 40th St.		
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> separated	8. DATE OF BIRTH 1-12-93	9. AGE (In years last birthday) 76
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Clerk		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. FATHER'S NAME Henry Kirby		14. MOTHER'S MAIDEN NAME Gatherine Grogan		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-07-3745		17. INFORMANT ADDRESS Mrs. Margaret W. Kirby 6141 Chinquapin Pkwy. Keswick Records
18. CAUSE OF DEATH 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Parkinson's Disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 2 years 4 years 13 years
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12 Oct 19 69 to 2 Dec 19 69 , that (I) (we) last saw the deceased alive on 2 Dec 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Aubrey D. Richardson M.D. XXXXXX XXXXXX XXXXXX				23B. DATE SIGNED 12-2-69
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS 700 W. 40th Street		
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) burial 12/4/69		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Road Balto., Md. 21212



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

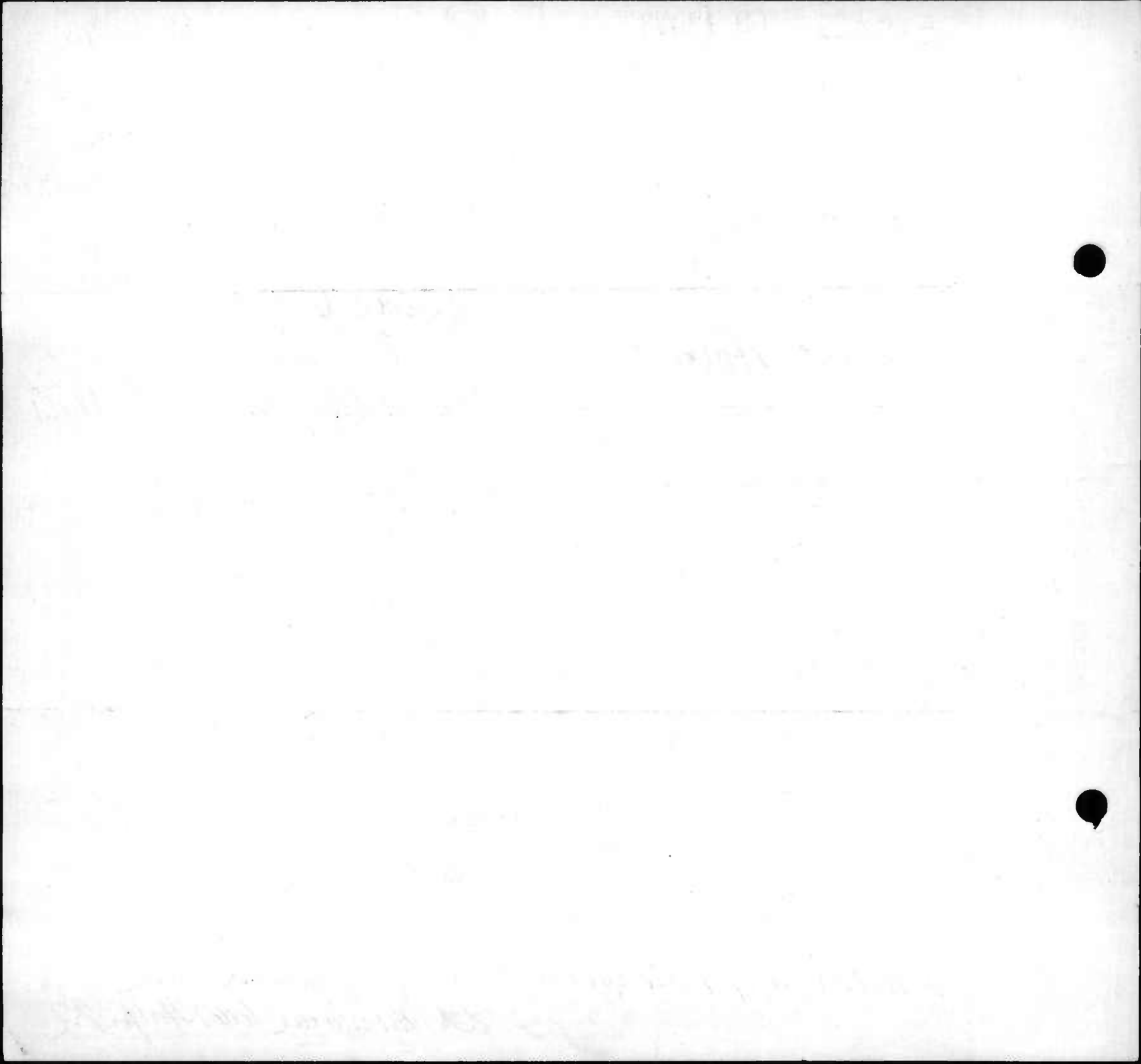
W-426		69 12072		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12072	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) WALKER, SANDRA LYNN				2. DATE AND HOUR OF DEATH 12-3-'69 9:35 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2778			
5. SEX F				6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-26-1943				9. AGE (In years last birthday) 26		10. Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) West Virginia	
13. FATHER'S NAME EARL S. JONES				14. MOTHER'S MAIDEN NAME Mae Eileen Sockman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS E. Stanley Jones 8329 Carrbridge Circle, Towson Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE PANCREATITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH ACUTE PANCREATITIS DUE TO, OR AS A CONSEQUENCE OF: Gram negative septic shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 DAYS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 11-30-1969		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POOR RISK		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-29-69 to 12-3-69 that (I) (we) last saw the deceased alive on 9:35 PM 12-3-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kasuke Tsujimoto, M.D.				23B. DATE SIGNED 12-3-'69		23C. PHYSICIAN'S NAME (Type) KASUKE TSUJIMOTO, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) cremation				24B. DATE 12/6/69		24C. NAME of CEMETERY or CREMATORY Greenmount Cem. Crematory	
24D. LOCATION Balto.				24E. LOCATION (City, town, or county) Balto.		24F. LOCATION (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969				25B. NAME OF REGISTRAR Mitchell Wiedefeld		25C. FUNERAL DIRECTOR Mitchell Wiedefeld Home 6500 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">E-562</h2>		<h2 style="margin: 0;">69 12073</h2>		<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2>		<h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		<h2 style="margin: 0;">REG. NO. 69 12073</h2>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Jessie Emerson</u>				2. DATE AND HOUR OF DEATH <u>12-1-69</u> <u>10:25</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>						A. STATE <u>MD.</u>		B. COUNTY <u>Baltimore Co.</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>6811 Campfield Rd.</u>									
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-13-87</u>		9. AGE (In years last birthday) <u>82</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Denver Col.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robert Robert</u>				14. MOTHER'S MAIDEN NAME <u>Reid</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Records (Guy Anne)</u>		ADDRESS <u>Campfield Rd.</u>	
18. <u>250.9</u>		CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Multiple arterial Embolism with Cerebral + Mesenteric Thrombosis</u>							
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____							
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes Mellitus</u>							
19A. DATE OF OPERATION <u>11/18/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Gangrene w/rd. 4. Sinus</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>9-28</u> 19 <u>69</u> to <u>12-1-</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12-1-</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Rajinder P. Gandhi</u>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-1-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>RAJINDER. P. GANDHI</u>						23D. ADDRESS <u>730 ASHBURTON ST. BALTIMORE MD. 21216</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1/5/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Concord Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Concord Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1969</u>		25B. NAME OF REGISTRAR <u>John E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>W. [unclear]</u>		ADDRESS <u>6607 Mayford Rd</u>			



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) POLLEY MARTIN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) 817 S. Charles Street		3. DATE PRONOUNCED DEAD Month Day Year December 3, 1969 Hour 9:00 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Nov 11-1906		10. AGE (In years last birthday) 63 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAM Forrest		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2201	
15. MOTHER'S MAIDEN NAME UNKNOWN		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT Ernest Swigert ADDRESS Above Address	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
22. DATE OF OPERATION		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		27. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		29. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/3/69	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)
Decent	12/5/69	Glen Haven Cem.	Glen Burnie AA Md.
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR	ADDRESS
DEC 8 1969	John E. Kelly	McCall	930 E. Fort Ave.

100-10000

AMERICAN EXAMINER'S CERTIFICATE OF ANALYSIS

100-10000

ANALYSIS MADE FOR THE GOVERNMENT

ANALYSIS MADE FOR THE GOVERNMENT

ANALYSIS MADE FOR THE GOVERNMENT

ANALYSIS MADE FOR THE GOVERNMENT

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ANALYSIS MADE FOR THE GOVERNMENT

EXAMINER'S BOND

ANALYSIS MADE FOR THE GOVERNMENT

P-452

69 12075

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12075

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET PLANSKY				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Day 4 Year 69 Hour 2:40 PM Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 100 1023 Hollins St. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month December Day 4 Year 1969 Hour 2:40 PM			
6. SEX Female				7. RACE White		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1803	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 10/17/1910		10. AGE (In years last birthday) 59		E. STREET AND NUMBER 1023 Hollins St.			
11. BIRTH PLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		14B. KIND OF BUSINESS OR INDUSTRY Restaurant		15. MOTHER'S MAIDEN NAME Unknown			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <input checked="" type="checkbox"/>		17. SOCIAL SECURITY NO. <input checked="" type="checkbox"/>		18. INFORMANT Mrs. Gertrude Carender		ADDRESS Box 366, Baltimore Md.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			21. AUTOPSY? (Yes or No) no		
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Tsodore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Tsodore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/5/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/69		24C. NAME of CEMETERY or CREMATORY Green Haven Cem.		24D. LOCATION (City, town, or county) (State) Green Haven Md.	
25A. DATE RECD. BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR John E. Taylor & Son Inc.		ADDRESS 901 Hollins St. 23, Md.	

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M-240

69 12076

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12076

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOLA MEISEL M. Meisel		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 634 N. Chester Street		3. DATE PRONOUNCED DEAD Month Day Year December 2, 1969 Hour 1:00 P. M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 004			
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
9. DATE OF BIRTH 21/13/1892		10. AGE (In years last birthday) 77	D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	E. STREET AND NUMBER 634 N. Chester Street
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Saleswoman		14B. KIND OF BUSINESS OR INDUSTRY Retail	13. FATHER'S NAME Frank Meisel
15. MOTHER'S MAIDEN NAME Anna Litz		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 2195411391		18. INFORMANT ADDRESS Mr. H. Bartlett Litz Water & Frederick St.	
19. 4/12/69 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/3/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/5/69	24C. NAME OF CEMETERY or CREMATORY Most Holy Redeemer	24D. LOCATION (City, town, or county) (State) Baltimore Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Leonard J. Fick Inc.	25C. FUNERAL DIRECTOR ADDRESS 5305 Harford Rd. 21214

09 18149

EXAMINER'S CERTIFICATE OF DEATH

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69 12077

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12077

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Albert E. Weir		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8.W. Madison St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 1 69 7:14 a.m.		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1102	
6. SEX male	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug 26, 1906		10. AGE (In years last birthday) 63	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Edward Weir		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		15. MOTHER'S MAIDEN NAME Mary Becker	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Will		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mr Leonard Fehlauer 717 Munsey Bldg.	
19. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/1/69					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12/3/69		24C. NAME of CEMETERY or CREMATORY Greenmount	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969			
25B. NAME OF REGISTRAR John E. Feltz		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. Baltimore, Maryland			

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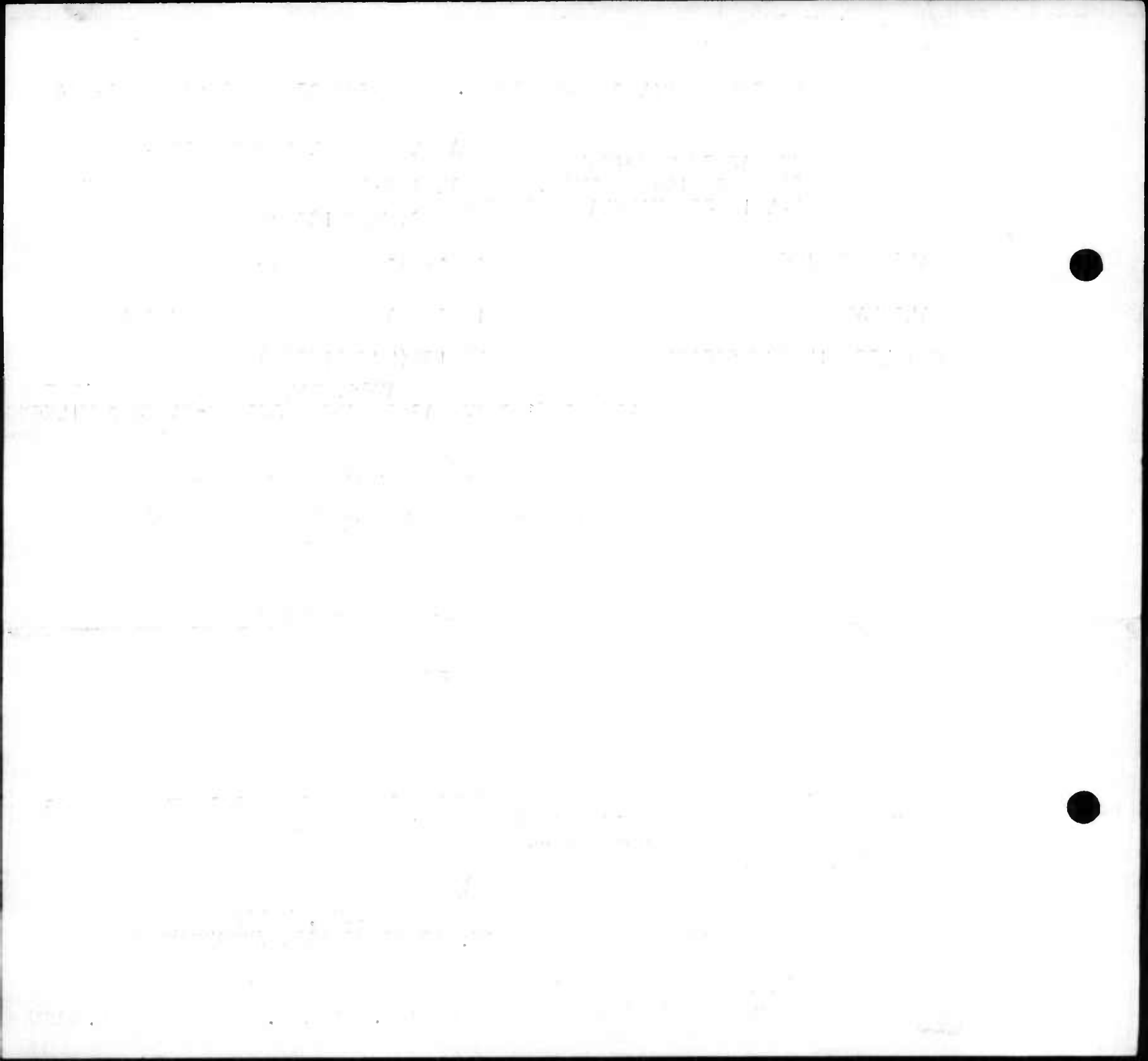
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-215		69 12078		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		69 12078	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		REG. NO.	
		HOGBOOM, MILTON CHARLES SR.		DECEMBER 4, 1969		1:15A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
ST. AGNES HOSPITAL		CATON & WILKENS AVES.		MARYLAND		BALTIMORE	
BALTIMORE, MARYLAND 21229		806 S. WARWICK RD.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
YES <input type="checkbox"/>		NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER			
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
MALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		10 18 89	
9. AGE (in years last birthday)		10. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
80		SALESMAN		MINNESOTA		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
CHARLES MILTON HOGBOOM				LOUISA (LUCHSINGER)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		216 07 6103		AVES. BALTO., MD.		21229	
				ST. AGNES HOSP RECORDS-CATON & WILKENS			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				and lateral myocardial infarct.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
II				(C) EMPHYSEMA - ANEMIA.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				20A. AUTOPSY? (Yes or No)			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 27 19 69 to DECEMBER 4 19 69 that (X) (we) last saw the deceased alive on DECEMBER 4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (he) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED		12/4/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		23E. FUNERAL DIRECTOR	
DR. CHARLES H. MORRIS				BALTO, MD 21229		LEONARD J. ROCK INC. 5305 HARFORD RD. 21214	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL				12/8/69		GARDENS OF FAITH CEMETERY	
24D. LOCATION (City, town, or county) (State)				24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
BALTIMORE MARYLAND				DEC 8 1969		Robert E. Fisher, M.D.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

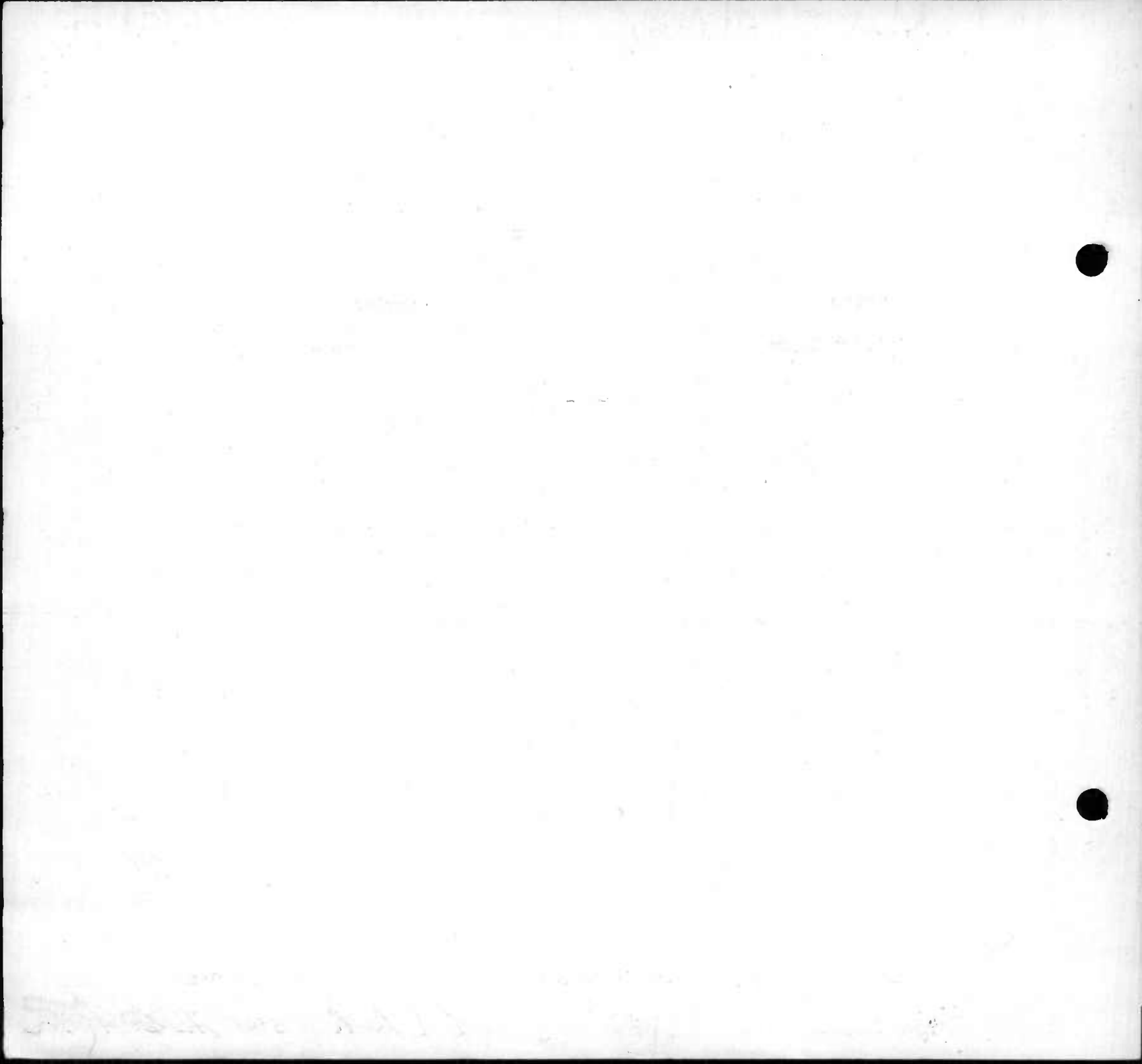
B-400 69 12079		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12079	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BELL NELLIE K.		2. DATE AND HOUR OF DEATH 12/3/69 2³⁰ P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2711		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSPITAL		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER GUILFORD TOWERS APT - 403	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/29/87	9. AGE (In years lost birthday) 82	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GUS TAVIS Gibson		14. MOTHER'S MAIDEN NAME ELIZABETH KIRWAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-44-9581		17. INFORMANT JAMES C. GIBSON APT ADDRESS ANDORRA CT. 2912	
18. 4309 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage 2 days ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. probable arteriosclerosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 12/3/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 12/1/69 to 12/3/69 , that (2) (we) lost saw the deceased alive on 12/3/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Anne L. Leddy M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ANNE L. LEDDY M.D.				23D. ADDRESS Union Memorial Hospital 33rd + Calvert	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/69		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		25D. ADDRESS 5305 Harford Rd. 21214			

address - 14 W Cold Spring La.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500		69 12080		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12080	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) MAGARET M. COYNE			
2. DATE AND HOUR OF DEATH 5:30 pm 12/3/69				M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Maryland		B. COUNTY 1547	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2313 N. Ellamont St.							
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 01-01-85		9. AGE (In years last birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Librarian		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Patrick Coyne				14. MOTHER'S MAIDEN NAME Rose ?			
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 218-22-0535		17. INFORMANT Richard Coyne 3524 Northwood Rd.	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) Abnrl flutter & Aseu + Diabetes ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Chronic brain syndrome				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/4 1969 to 12/3 1969 , that (I) (we) lost saw the deceased alive on 5:30 pm 12/3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rheske				23B. DATE SIGNED 12/3/69			
23C. PHYSICIAN'S NAME (Type) PRAJIMA CHASTAGIR				23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/69		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Patricia E. Taylor		25C. FUNERAL DIRECTOR L P Rush		ADDRESS 5305 Hartford Rd	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>4-620 69 12081 BALTIMORE CITY HEALTH DEPARTMENT 69 12081</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>REG. NO. _____</p>	
<p>BIRTH NO.</p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>1. NAME OF DECEASED (Type or Print)</p> <p><i>HARRIS, Delmas</i></p>		<p><i>12-5-69</i> <i>10</i> A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><i>LUTHERAN HOSPITAL OF MARYLAND</i> <i>730 ASHBURTON STREET</i> <i>BALTIMORE, MD 21216</i></p>		<p>A. STATE B. COUNTY</p> <p><i>MARYLAND - BALTO. CITY</i> <i>1503</i></p>	
<p>C. CITY OR TOWN</p> <p><i>BALTIMORE</i></p>		<p>D. INSIDE CITY LIMITS?</p> <p>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER</p> <p><i>2400 BAKER STREET</i></p>			
<p>5. SEX</p> <p><i>M.</i></p>	<p>6. RACE</p> <p><i>N.</i></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/></p> <p>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p> <p><i>3-20-09</i> <i>60</i></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><i>Retired Porter</i></p>		<p>11. BIRTHPLACE (State or foreign country)</p> <p><i>NORTH CAROLINA</i></p>	
<p>13. FATHER'S NAME</p> <p><i>John Harris</i></p>		<p>14. MOTHER'S MAIDEN NAME</p> <p><i>Alice Harris</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><i>UNKNOWN</i></p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT</p> <p><i>WIFE - 2400 BAKER STREET</i></p>		<p>ADDRESS</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>cerebral hemorrhage</i></p> <p>(B) <i>arterial hypertension</i></p> <p>(C) _____</p>	
<p style="text-align: center;">II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p> <p><i>0</i></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p> <p><i>No</i></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p><input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p> <p>(APPROX.)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p>21F. HOW DID INJURY OCCUR?</p>			
<p>22. I certify that (I) (this hospital) attended the deceased from <i>12-4</i> <i>1969</i> to <i>12-5</i> <i>1969</i>, that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date <i>12-5-69</i> and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p><i>Violeta R. Camarra-R</i></p>		<p>23B. DATE SIGNED</p> <p><i>12-5-69</i></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p><i>VIOLETA R. CAMARRA R. M.D.</i></p>		<p>23D. ADDRESS</p> <p><i>731 Ashburton St. Baltimore Md</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p><i>Burial</i></p>		<p>24B. DATE</p> <p><i>12/10/69</i></p>	
<p>24C. NAME OF CEMETERY or CREMATORY</p> <p><i>Traver Memorial Park</i></p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p><i>Laurel Md</i></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><i>DEC 8 1969</i></p>		<p>25B. NAME OF REGISTRAR</p> <p><i>John E. Taylor</i></p>	
<p>25C. FUNERAL DIRECTOR</p> <p><i>Williams Funeral Home</i></p>		<p>ADDRESS</p> <p><i>319 W. Snowden St.</i></p>	

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Handwritten notes, possibly a list or index, located in the upper right quadrant of the page.

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Handwritten notes at the bottom of the page, possibly a summary or conclusion.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-536		69 12082		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12082	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Ethel Mae Henderson</u>				2. DATE AND HOUR OF DEATH <u>December 5, 1969</u> <u>8:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2201</u>			
5. SEX <u>Female</u>		6. RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-3-20</u>	
9. AGE (In years last birthday) <u>49</u>		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Donald Henderson</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Hospital Clinical Record Brieft.</u>	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CA of Lung.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Known / mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:							
19A. DATE OF OPERATION <u>12</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Sudden Paraplegia</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec. 4</u> 19 <u>69</u> to <u>Dec. 5</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Dec. 5</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Donald P. Sickler M.D.</u>				23B. DATE SIGNED <u>Dec 5, 69</u>			
23C. PHYSICIAN'S NAME (Type) <u>DONALD P. SICKLER</u>				23D. ADDRESS <u>University Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/8/1969</u>		24C. NAME OF CEMETERY or CREMATORY <u>W. Calvary Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Cedar Hill Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1969</u>		25B. NAME OF REGISTRAR <u>Walter E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Williams Funeral Home</u>		ADDRESS <u>399 N. Howard St.</u>	

Chase of 1871-72

Final Paper

Donald Henderson

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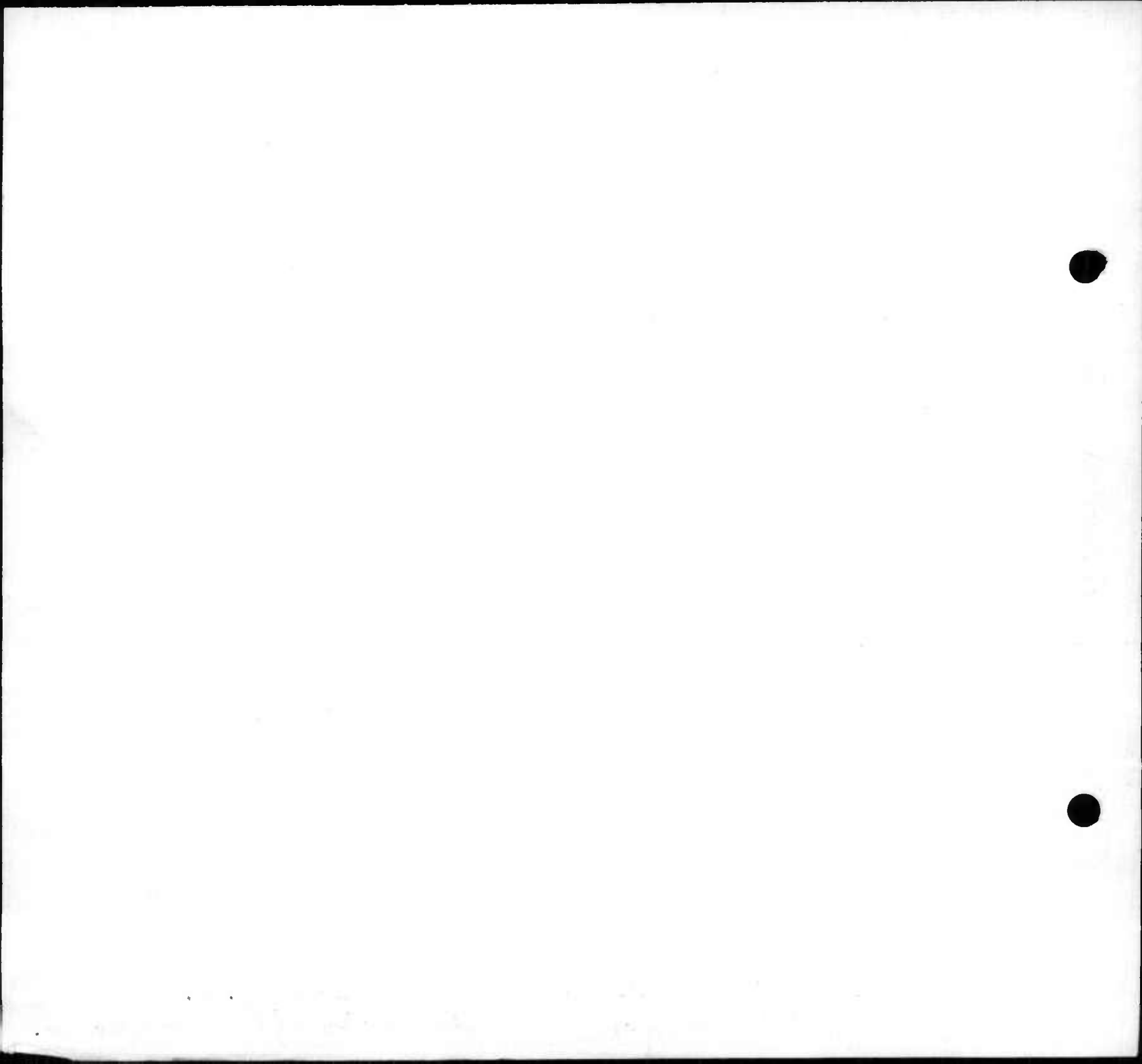
Donald A. Brown

7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

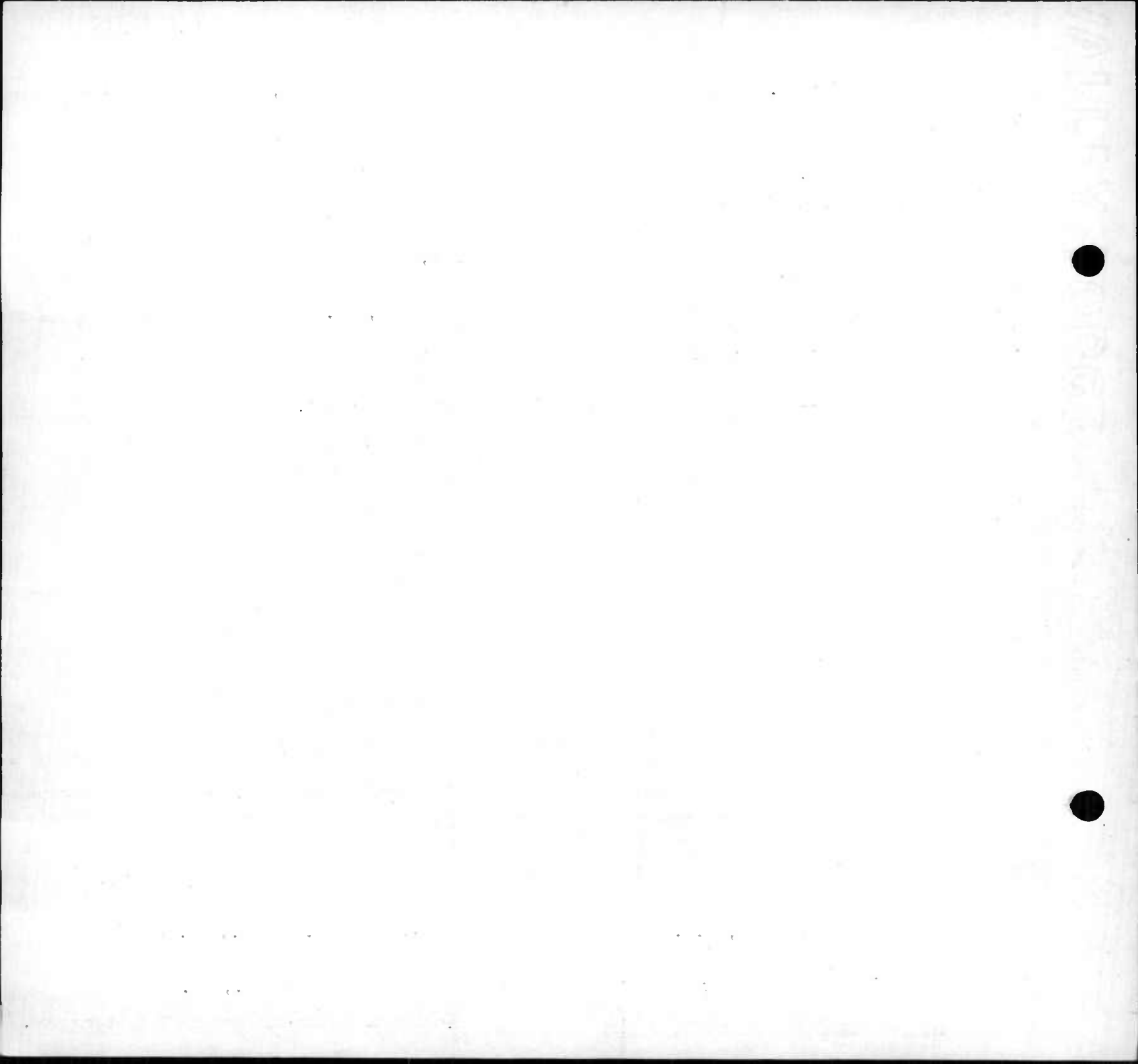
S-530		69 12083		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12083	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>VICTORIA SMITH</i>		2. DATE AND HOUR OF DEATH <i>12:25 P.M. 12-7-69</i>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>49 North Charles Hospital</i>				A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>					
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-16-24</i>		9. AGE (In years last birthday) <i>45</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>W. Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>George Chice</i>				14. MOTHER'S MAIDEN NAME <i>HARNAK STEAR</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>24-56711</i>		17. INFORMANT <i>Goldie Dawson</i>		ADDRESS <i>State</i>			
18. <i>44041</i>		CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Uremia</i>							
ANTECEDENT CAUSES		(B) <i>Generalized Arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF:							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____							
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>12/6/69</i> to <i>12-7-69</i> that (I) (we) last saw the deceased alive on <i>12-7-69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Nilda R. England Cabling MD</i>				23B. DATE SIGNED <i>12/7/69</i>					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<i>Removal</i>		<i>12/10/69</i>		<i>Davis Funeral Home</i>		<i>Clarksburg W. Va.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Farber MD</i>		25C. FUNERAL DIRECTOR <i>Bruzdzinski Funeral Home</i>		ADDRESS <i>1407 Eastern Ave.</i>			



FUNERAL DIRECTOR: IMPORTANT

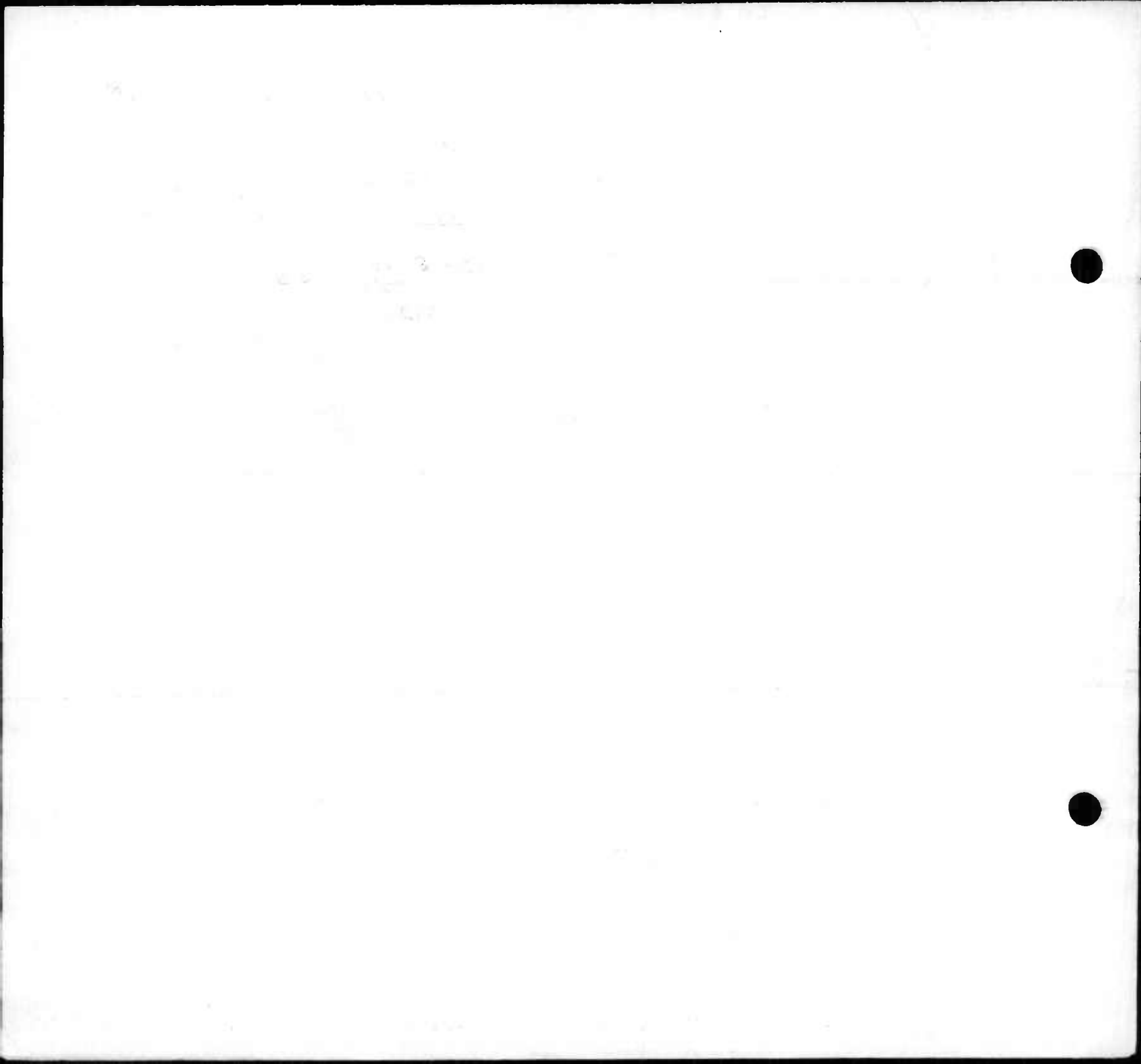
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-165 69 12084				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12084	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) JOHN I. EBERWEIN		2. DATE AND HOUR OF DEATH December 6, 1969 11:40 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		5300	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 31 Baltimore City Hospital				C. CITY OR TOWN sssex 21221		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 317 Worton Road				8. DATE OF BIRTH June 4, 1915		9. AGE (In years lost birthday) 54	
5. SEX Male		6. RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Fitter	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship Fitter		10B. KIND OF BUSINESS OR INDUSTRY Coast Gaurd Yard		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Eberwein				14. MOTHER'S MAIDEN NAME Katherine Mewcome			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No --				16. SOCIAL SECURITY NO. 216 07 3055		17. INFORMANT Elizabeth Eberwein Same	
18. I 162.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH SQUAMOUS CELL CARCINOMA OF LUNG (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 1/2 mo.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) _____		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____			
22. I certify that (I) (this hospital) attended the deceased from Nov. 14 19 69 to Dec. 6 19 69 , that (I) (we) last saw the deceased alive on Dec. 3 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (and) (did not) view the body after death.							
23A. SIGNATURE M. Rainess, M.D.				23B. DATE SIGNED 12-8-69			
23C. PHYSICIAN'S NAME (Type) Morris Rainesss, M.D.				23D. ADDRESS 1105 Eastern Ave. Balto., Md. 21221			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69		24C. NAME OF CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Prudzinski Funeral Home		ADDRESS 1407 Eastern Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-162		69 12085		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12085	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Joseph M. Hybrzynski</i> <i>HYBRZYNSKI Mr. Joseph M.</i>		2. DATE AND HOUR OF DEATH <i>12-5-1969</i>		<i>11:30 pm</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Church Home & Hospital, 100 N Broadway, Baltimore MD 21224</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>203</i>			
5. SEX <i>male</i>		6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>12-8-00</i>	
9. AGE (in years last birthday) <i>68 (68)</i>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>		11. BIRTHPLACE (State or foreign country) <i>MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Michael Hybrzynski</i>				14. MOTHER'S MAIDEN NAME <i>Anastasia Nowak</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <i>Yes WW II</i>		16. SOCIAL SECURITY NO. <i>214-05-3385</i>		17. INFORMANT <i>Francis Garlin (Sister) 1818 Fleet Street, Baltimore MD 21224</i>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Distruptive jaundice</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic alcoholism</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Portal cirrhosis</i> (C) _____			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If not, medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (4) (this hospital) attended the deceased from <i>11-25-1969</i> to <i>12-5-1969</i> that (1) (we) last saw the deceased alive on <i>12-5-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Albin Samad</i>				23B. DATE SIGNED <i>12/5/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>ABDUS SAMAD</i>		23D. ADDRESS <i>Church Home & Hospital 100 N Broadway Baltimore MD 21224</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/9/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>St. Stanislaus</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1969</i>		25B. NAME OF REGISTRAR <i>John E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR & ADDRESS <i>J.M. SUDOWSKI & SONS, 1808 EASTERN AVE</i>			



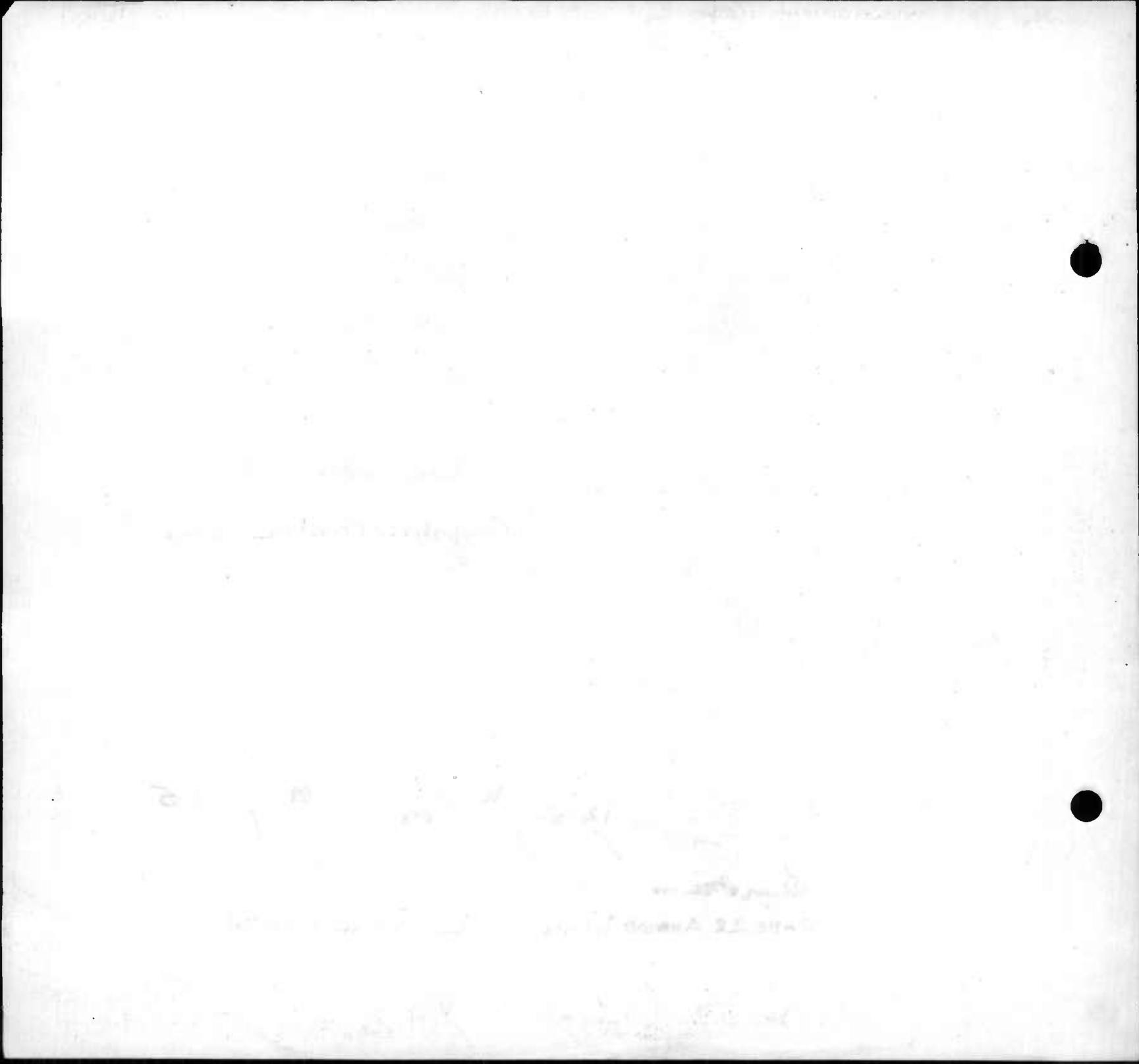
J-210

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 12086				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12086	
1. NAME OF DECEASED (Type or Print) <i>Lillie Joseph</i>				2. DATE AND HOUR OF DEATH <i>12-5-69</i> <i>5:20 P.M.</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Lutheran Hospital</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1304</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1706 Queens Falls Pkwy</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-19-96</i>	9. AGE (In years last birthday) <i>73</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		
11. BIRTHPLACE (State or foreign country) <i>Ala</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>				
13. FATHER'S NAME <i>William Moss</i>			14. MOTHER'S MAIDEN NAME <i>Maulsey Moss</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>			16. SOCIAL SECURITY NO. <i>271-18-1952</i>		17. INFORMANT <i>Willie B. Cole</i> ADDRESS <i>1706 Queens Falls Pkwy, Balto., Md.</i>		
18. <i>427.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cardiorespiratory Failure</i> (B) <i>Congestive Cardiac Failure</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>10-30-69</i> to <i>12-5-69</i> , that (I) (we) last saw the deceased alive on <i>12-5-69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Zaheer Ahmad Khan</i>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>ZAHEER AHMAD KHAN</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-11-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Greenview Mem.</i>		24D. LOCATION (City, town, or county) (State) <i>Laurel, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 8 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>William Reese, Jr.</i>		25D. ADDRESS <i>Annapolis, Md.</i>	



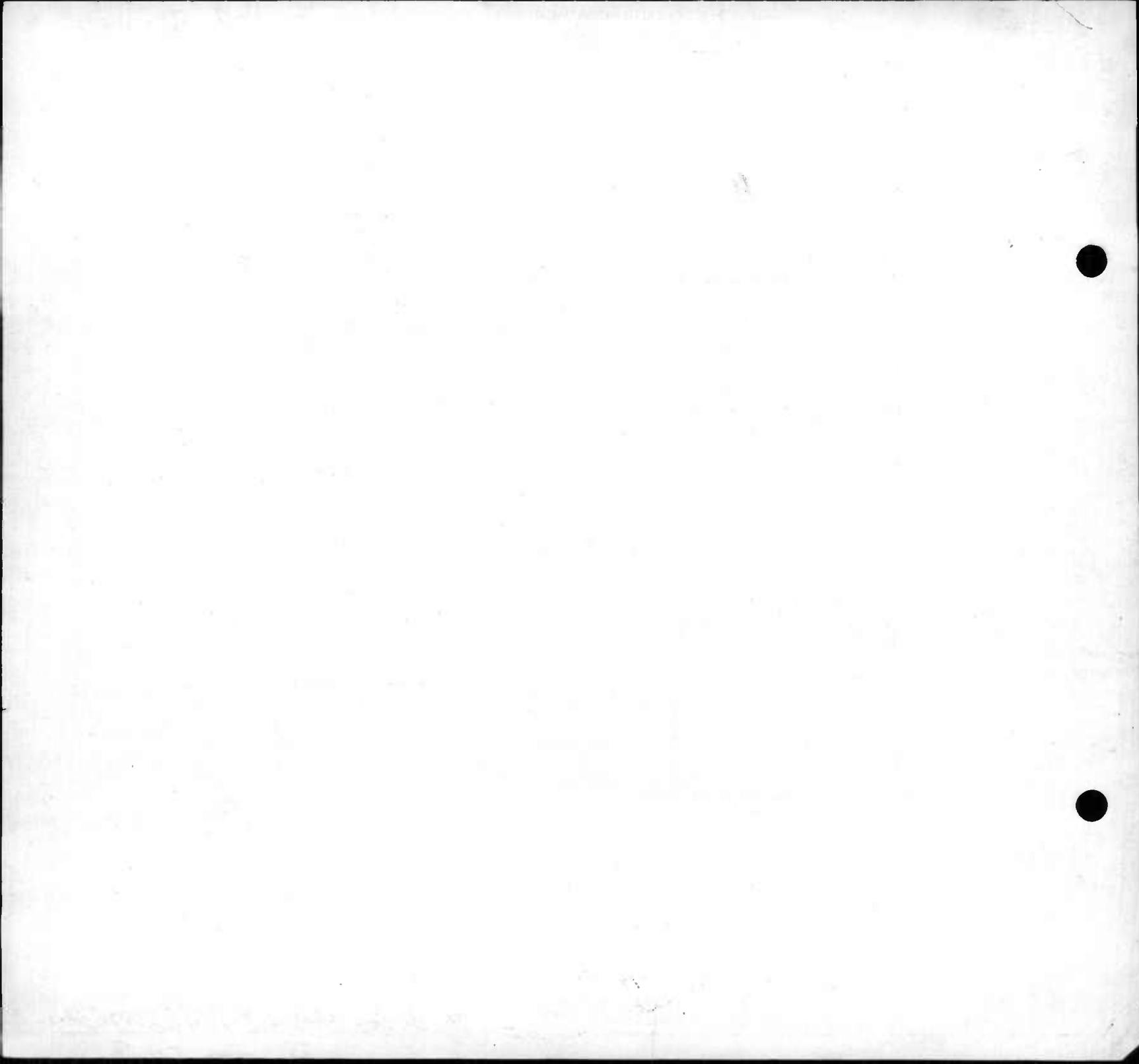
FUNERAL DIRECTOR: IMPORTANT

CARLSON, E.
129 24 84
6-6421

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V.H. Johnson

BIRTH NO. 69 12087				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12087	
1. NAME OF DECEASED (Type or Print) ERNEST CARLSON				2. DATE AND HOUR OF DEATH 05 3 15 PM Dec 12, 1969 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL, MONUMENT ST 33				A. STATE MD. B. COUNTY BALTO. CITY		C. CITY OR TOWN Baltimore	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1744 E. Lombard St.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/2/98	9. AGE (In years lost birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Seaman		11. BIRTHPLACE (State or foreign country) SWEDEN		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME UNK				14. MOTHER'S MAIDEN NAME UNK.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK COAST GUARD		16. SOCIAL SECURITY NO. 229-14-9459		17. INFORMANT MARY CARLSON		ADDRESS NORFOLK VA.	
18. 4 12 41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II				CAUSE OF DEATH IMMEDIATE CAUSE Ventricular arrest. DUE TO, OR AS A CONSEQUENCE OF: ASCVD.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 35 min.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A) Abdominal arterial vascular obstruction.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE B.G. Brown M.D., PHD DEGREE						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) B.G. BROWN M.D., PHD DEGREE				23D. ADDRESS Johns Hopkins Hospital.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC 9 1969		24C. NAME OF CEMETERY OR CREMATORY MT CARMEL CEM.		24D. LOCATION (City, town, or county) (State) ODONNELL ST MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR John E. Vabey		25C. FUNERAL DIRECTOR THE DIPPEL BROS INC		ADDRESS 1800 E LOMBARD ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 12088 CERTIFICATE OF DEATH

REG. NO. 69 12088

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Arthur E. McKinish

2. DATE AND HOUR OF DEATH

Dec 5, 1969 8:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00622 East Baltimore Street

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE B. COUNTY

Maryland 301

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

E. STREET AND NUMBER

1622 East Baltimore St.

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☒ NEVER MARRIED ☐

WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

Jan 10, 1912

9. AGE (In years last birthday)

57

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Beth Steel

11. BIRTHPLACE (State or foreign country)

Ellijay, Georgia

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Alex McKinish

14. MOTHER'S MAIDEN NAME

Nancy Jane Powell

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

254-12-6524

17. INFORMANT

Lillie Elmore 441 52nd St. 21224

ADDRESS

18. 412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral Vascular Accident

Several months

(B) DUE TO, OR AS A CONSEQUENCE OF:

Arteriosclerosis C.V.D. - Congestive Failure

5 years

(C) EMPHYSEMA

Pulmonary 7 years

7 years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

None

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from June 10, 1967 to December 5, 1969, that (I) (we) last saw the deceased alive on Dec 4, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J. Miller

MD

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

Dec 6, 1969

23C. PHYSICIAN'S NAME (Type)

Jacob M. Miller M.D.

23D. ADDRESS

1613 East Baltimore St.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

Dec 9, 1969

24C. NAME OF CEMETERY OR CREMATORY

Liberty Church Cem.

24D. LOCATION

Ellijay, Georgia

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1969

25B. NAME OF REGISTRAR

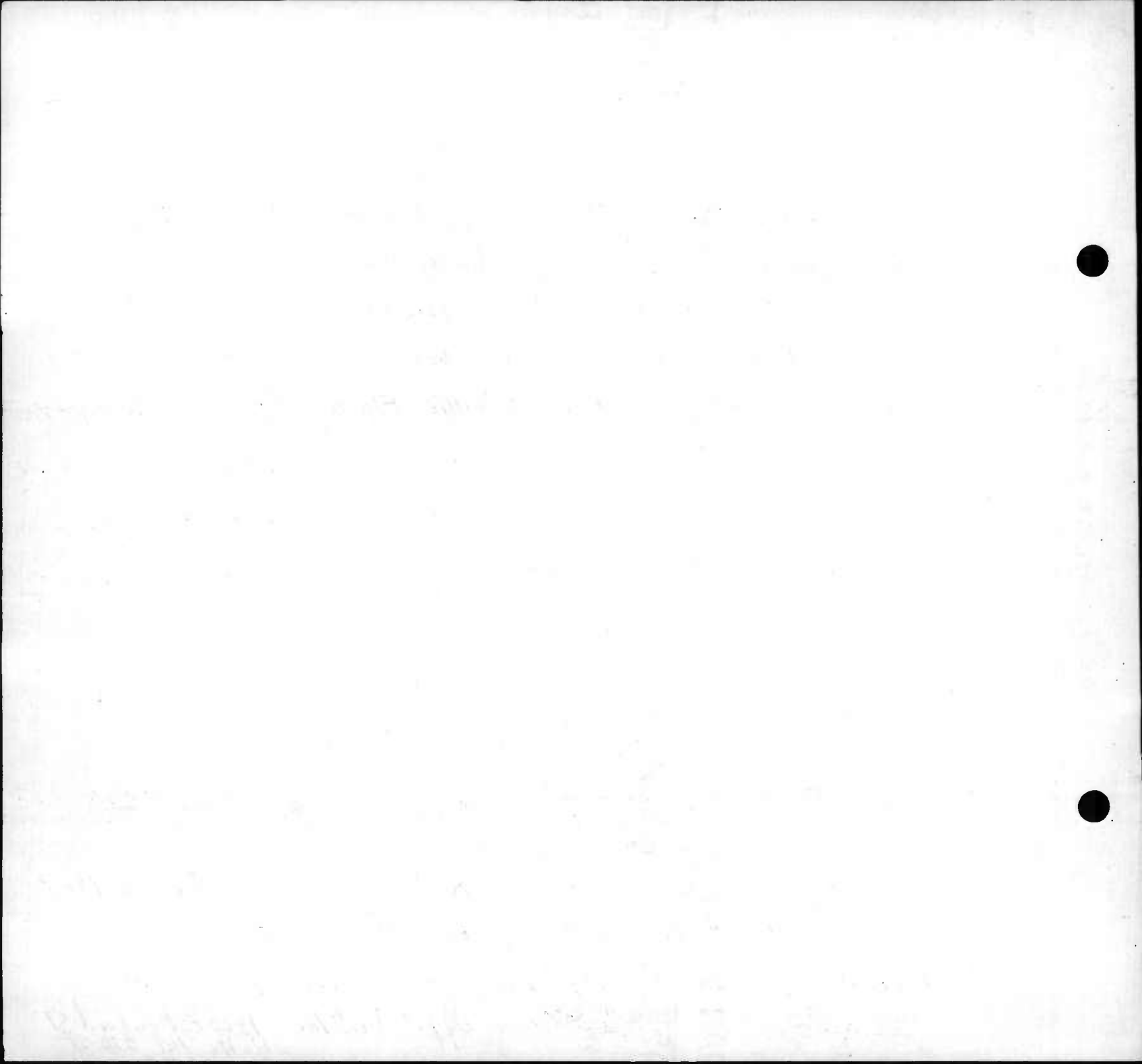
John E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Doppel Bros Inc.

ADDRESS

1800 E. Lombard St. Balto. Md 21231



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12089

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 12089

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MILHOLLAND, MICHAEL JOSEPH

2. DATE AND HOUR OF DEATH

December 5, 1969

3:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)VETERANS ADMINISTRATION HOSPITAL
3900 LOCH RAVEN BLVD, BALTIMORE, MD.4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

MARYLAND

BALTIMORE

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1743 WAVERLY WAY,

5. SEX

MALE

6. RACE

CAUCASIAN

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8-21-93

9. AGE (In years
last birthday)

76

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

BARTENDER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MD.

12. CITIZEN OF WHAT COUNTRY?

UNITED STATES

13. FATHER'S NAME

JOHN M. MILHOLLAND

14. MOTHER'S MAIDEN NAME

ELLEN MACKEY

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

YES

4/25/18-11/15/18

16. SOCIAL
SECURITY NO.

214-03-38-26

17. INFORMANT

VA Hospital Records

ADDRESS

3900 Loch Raven Blvd, Baltimore, Md.

18.

41091

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

CONGESTIVE HEART FAILURE

UNKNOWN

DUE TO, OR AS A CONSEQUENCE OF:

(B)

MYOCARDIAL INFARCTION

UNKNOWN

DUE TO, OR AS A CONSEQUENCE OF:

(C) ARTERIOSCLEROTIC HEART DISEASE

UNKNOWN

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

YES

21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~(X)~~ (this hospital) attended the deceased from December 1 1969 to December 5 1969,
that ~~(X)~~ (we) last saw the deceased alive on December 5 1969 and that in ~~(my)~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~(X)~~ (We) (did) ~~XXXX~~ view the body after death.

23A. SIGNATURE

Michael G. Hayes, MD

Attending
Phys. ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

12-5-69

23C. PHYSICIAN'S
NAME (Type)

MICHAEL G. HAYES, M. D.

23D. ADDRESS

VA Hospital

3900 Loch Raven Blvd, Baltimore, Md. 21218

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/9/69

24C. NAME OF CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1969

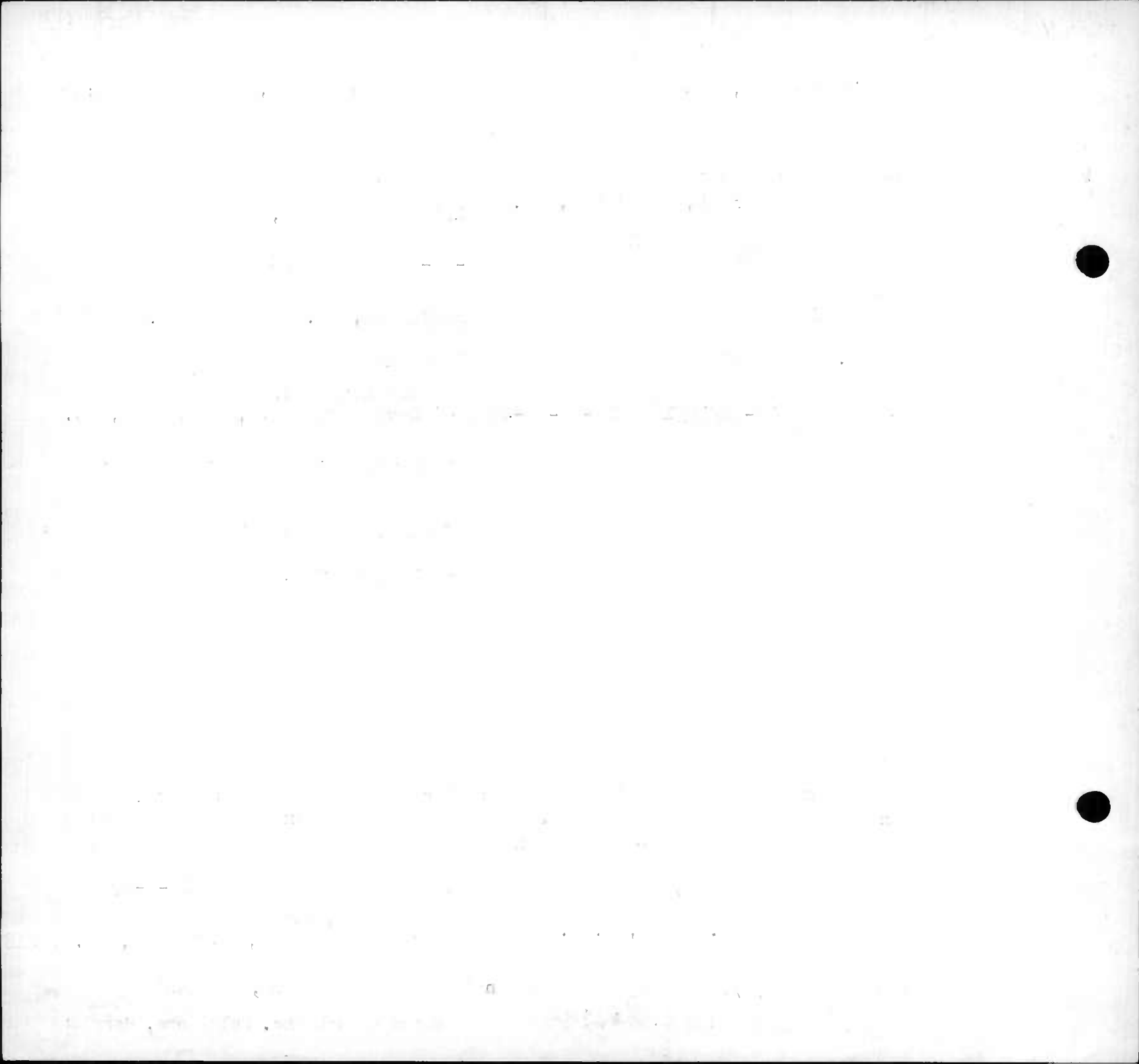
25B. NAME OF REGISTRAR

Robert E. Taylor, R.D.

25C. FUNERAL DIRECTOR

Leonard J Ruck Inc. Baltimore, Maryland

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

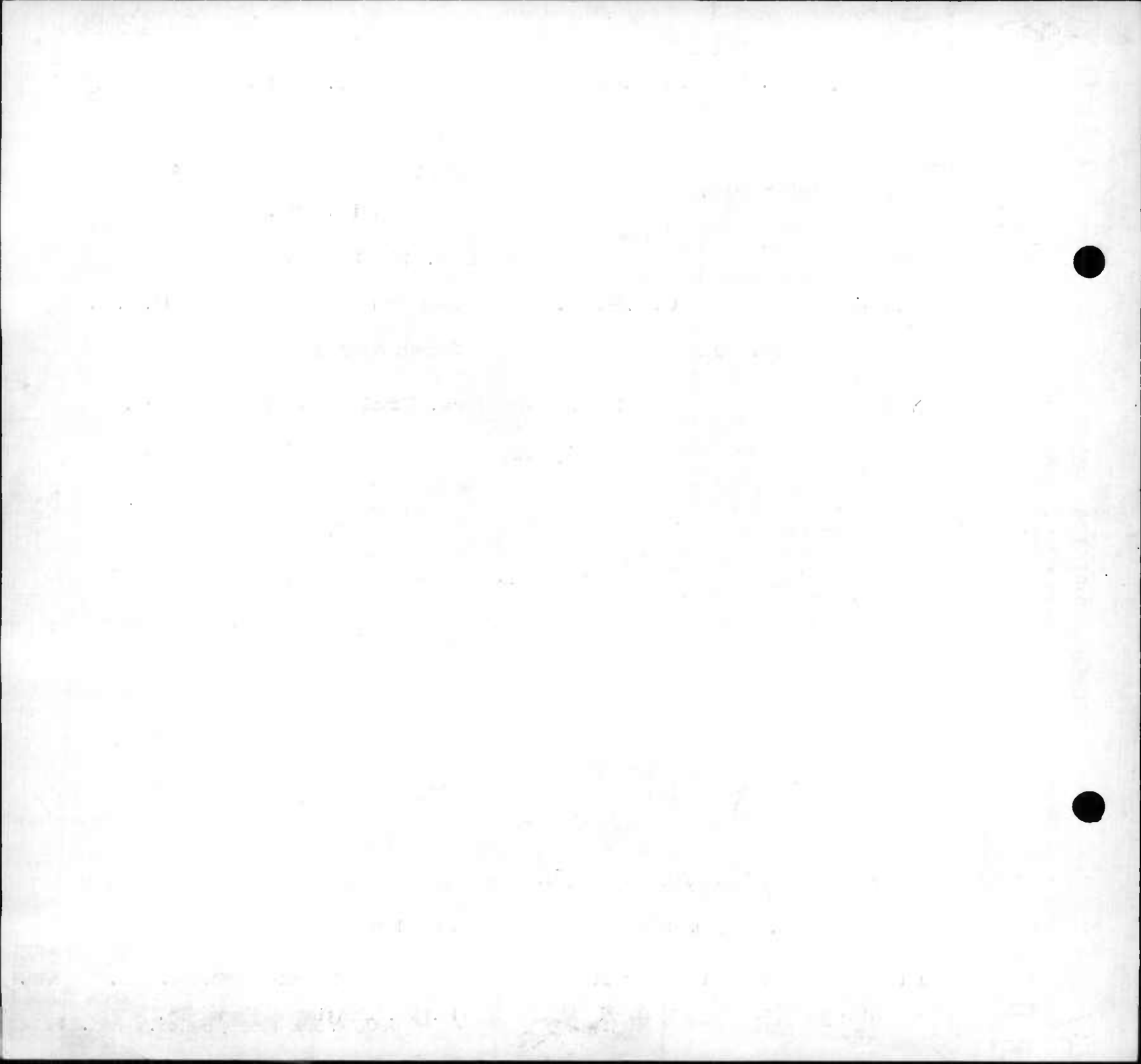
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BALTIMORE CITY HEALTH DEPARTMENT

69 12090 CERTIFICATE OF DEATH

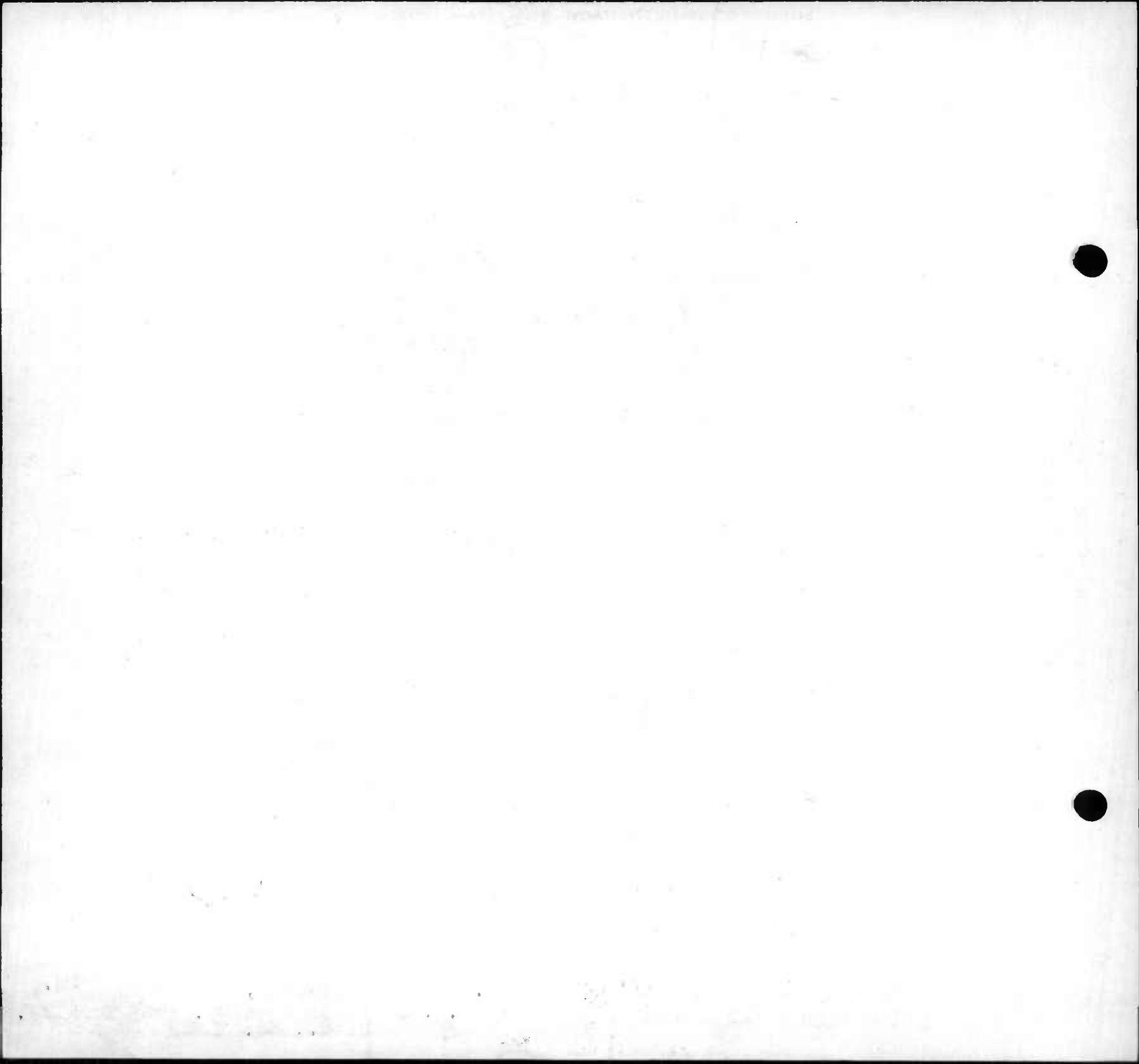
REG. NO. 69 12090

BIRTH NO. 69 12090		2. DATE AND HOUR OF DEATH Dec. 6, 1969 2:15 P.M.	
1. NAME OF DECEASED (Type or Print) S. Webster Tull		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2710	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 909 Belgian Avenue 00		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 909 Belgian Ave.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 19, 1896 72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10B. KIND OF BUSINESS OR INDUSTRY U.S.F. & G.	9. AGE (In years last birthday) 72 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Aston Tull		14. MOTHER'S MAIDEN NAME Sarah Mather	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 215-07-8246	17. INFORMANT Mrs. Ethelwyn Tull
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 41247-148-1 CORONARY THROMBOSIS (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A.S. C.V. DISEASE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) MALABSORPTION SYNDROME II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CARCINOMA-PYRIFORM SINUS 19A. DATE OF OPERATION 2		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN YEARS(?) 3 YEARS 3 YEARS	
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Aprox.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from APRIL 1964 to DEC. 6, 1969, that (I) (we) last saw the deceased alive on DEC. 4, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE Arthur Karfgin M.D.		23B. DATE SIGNED 12/8/69	
23C. PHYSICIAN'S NAME (Type) Dr. Arthur Karfgin		23D. ADDRESS 1532 Havenwood Road	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-1969	
24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Robert E. Tully, Sr.	
25C. FUNERAL DIRECTOR H.O.W. Jenkins & Sons Co.		ADDRESS 4905 York Road Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

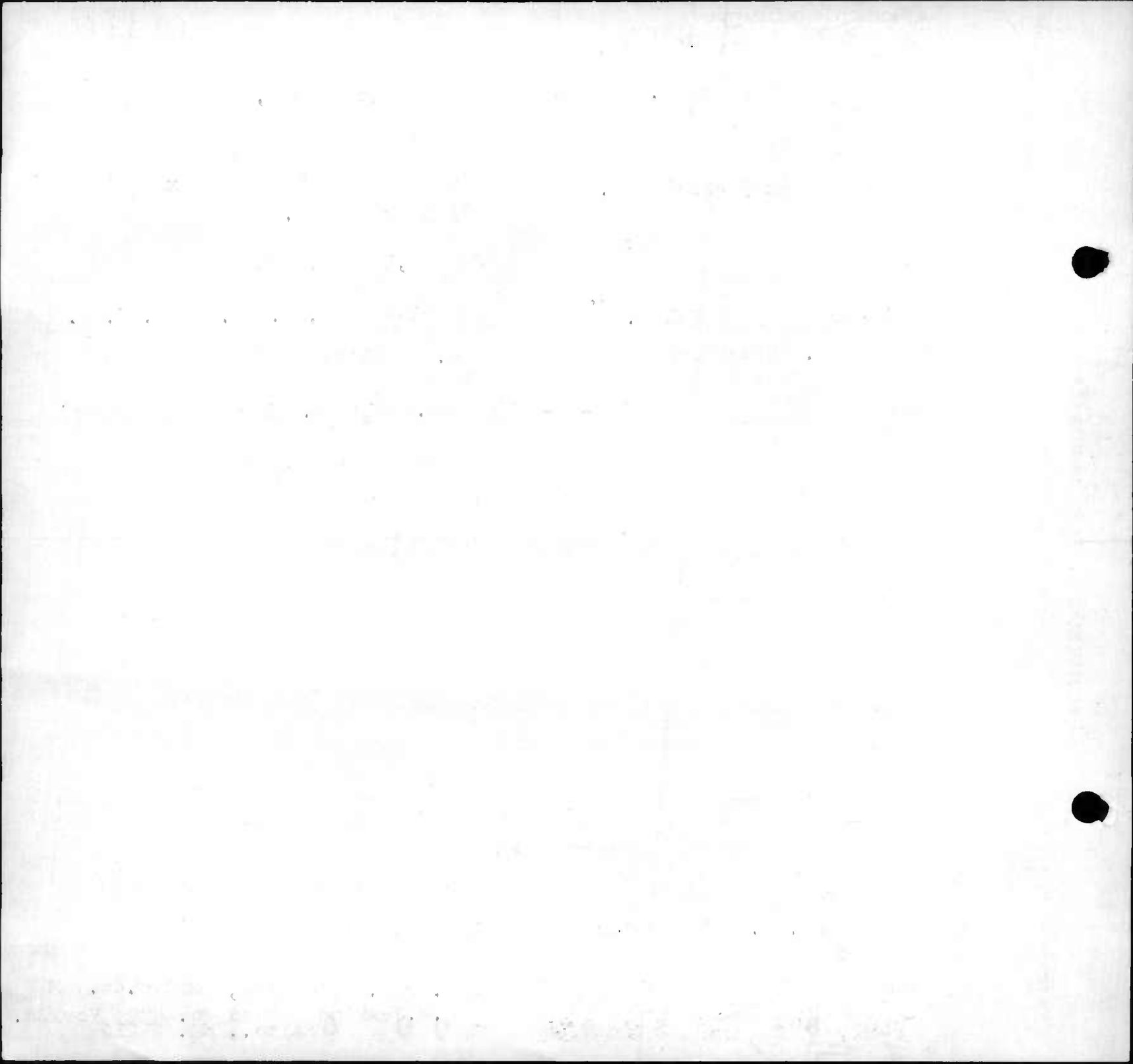
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12091
BIRTH NO. 69 12091		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Wafield Mrs Betty Byrd		2. DATE AND HOUR OF DEATH 12-7-69 2⁴⁵ Pm		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 91 Keswick Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1307		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 Keswick Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 5-4-1894		9. AGE (In years last birthday) 75 yrs		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Bristol, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Franklin Chaney		
14. MOTHER'S MAIDEN NAME ELEANOR (Nellie) Welch Smith		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 213-58-1394		17. INFORMANT Harold S. McTaul, R.N.		
18. CAUSE OF DEATH 707.0 I		ADDRESS *Keswick*		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Septicemia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Multiple infected decubitus ulcers 9 months				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Arteriosclerotic Parkinsons Disease 10 years				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that the (this hospital) attended the deceased from February 2, 1968 to December 7, 1969 , that the (we) last saw the deceased alive on December 7, 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. the (We) (did) (did not) view the body after death.				
23A. SIGNATURE W.B. Daniels, Jr. M.D.		23B. DATE SIGNED 12/7/69		23C. PHYSICIAN'S NAME (Type) W.B. Daniels, Jr. M.D.
23D. ADDRESS Keswick, Baltimore, Md., 21218				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69		24C. NAME OF CEMETERY or CREMATORY Oak Grove Cem.
24D. LOCATION Glenwood, Md.				
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12092
BIRTH NO. 69 12092		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Schuyler C. Blackburn		2. DATE AND HOUR OF DEATH December 6, 1969 7:30 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3303 Frisby St.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 903 C. CITY OR TOWN Baltimore 21218 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3303 Frisby St.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1898	9. AGE (In years lost birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10B. KIND OF BUSINESS OR INDUSTRY H20 Dept. Balto. City		11. BIRTHPLACE (State or foreign country) Charles Town, W. Va.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James M. Blackburn		
14. MOTHER'S MAIDEN NAME M. Oliva Clapham		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		
16. SOCIAL SECURITY NO. 214-40-4414		17. INFORMANT ADDRESS Mrs. Louise G. Blackburn (Same)		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Signified as the aneurysm ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Essential hypertension		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (the hospital) attended the deceased from January 1967 to December 6, 1969 , that (I) (we) last saw the deceased alive on December 6, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE A. Allan Spier		23B. DATE, SIGNED 12/8/69		
23C. PHYSICIAN'S NAME (Type) Dr. A. Allan Spier		23D. ADDRESS 1501 Pentridge Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/10/69	24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Grds. Timonium, Balto. Co., Md.		24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12093

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 12093

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Dr. Francis A. Ellis

2. DATE AND HOUR OF DEATH

12-6-69

10:15 A.M.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Keswick Home for Incurables of

Baltimore City

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Keswick Home

Baltimore, Md.

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

700 W. 40th St. Balto., Md. 21211

5. SEX

M

6. RACE

W

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

10-3-1899

9. AGE (In years
last birthday)

70

If Under 1 Yr.
Months: DaysIf Under 24 Hrs.
Hours: Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Physician

10B. KIND OF BUSINESS OR INDUSTRY

Medicine

11. BIRTHPLACE (State or foreign country)

Balto., Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John H. Adams

14. MOTHER'S MAIDEN NAME

Catherine O. Adams

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

215-05-2146A

17. INFORMANT

Mrs. Margaret B. Ellis, 8 E. Madison

ADDRESS

St.

18. 433.9 I

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral thrombosis

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Cerebral arteriosclerosis

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 months

several
years

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

Pneumonia secondary to catheter

2 months

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from Nov. 25 1969 to Dec. 6 1969,
that (we) last saw the deceased alive on 12/6/69 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (We) (did) (did not) view the body after death.

23A. SIGNATURE

W.B. Daniels, Jr.

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/6/69

23C. PHYSICIAN'S
NAME (Type)

W.B. DANIELS, Jr. M.D.

DEGREE

23D. ADDRESS

Keswick, Baltimore, Md., 21218

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/9/69

24C. NAME OF CEMETERY OR CREMATORY

New Cathedral

24D. LOCATION

(City, town, or county)

Baltimore

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1969

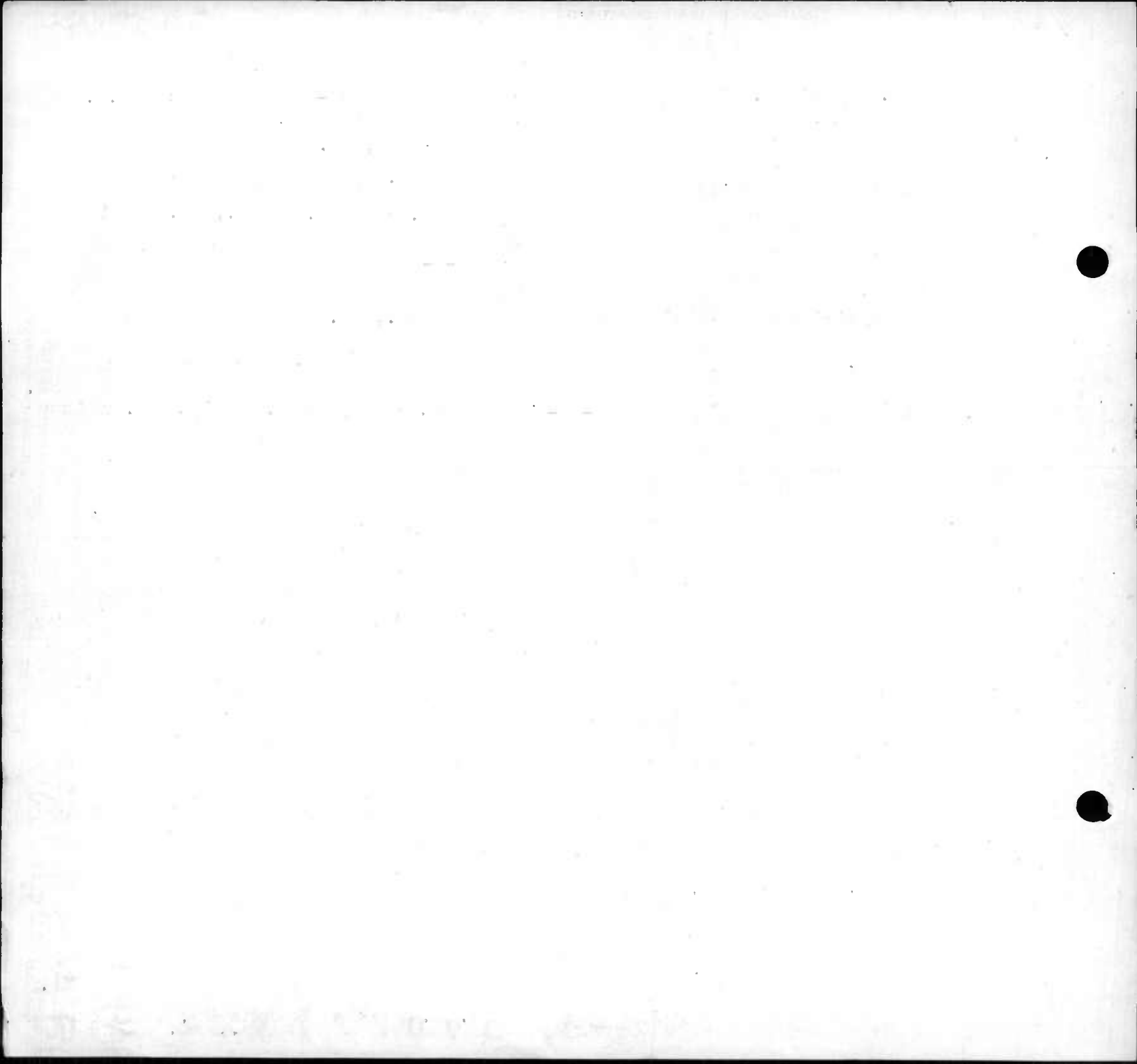
25B. NAME OF REGISTRAR

R. E. Taylor

25C. FUNERAL DIRECTOR

H. W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212

ADDRESS

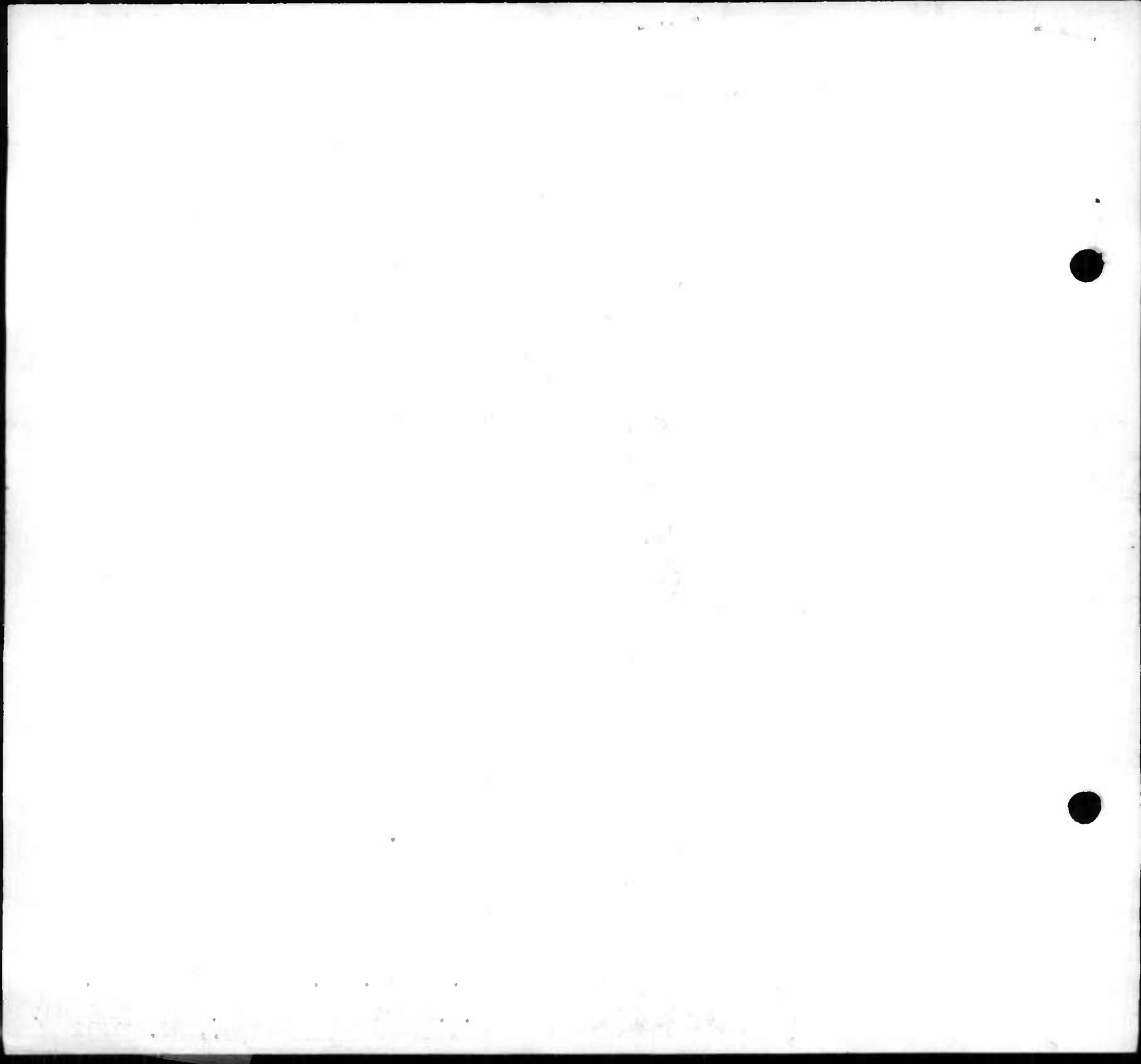


Released in approval ME - Dr. M. Mathews - 12/5/69

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69 12094		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12094	
1. NAME OF DECEASED (Type or Print) JUDITH B. MATHEWS		2. DATE AND HOUR OF DEATH Dec. 5, 1969 1:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 12.02 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 320 E. UNIVERSITY PARKWAY			
5. SEX F	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01-25-88	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN C. MATHEWS			
14. MOTHER'S MAIDEN NAME FRANCES COLVIN		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 413-09-5655A		17. INFORMANT HOSPITAL RECORD		ADDRESS U.M.H.	
18. 4/2/41-88 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE HEMORRHAGE OF DUE TO, OR AS A CONSEQUENCE OF: Fracture of femur. UNKNOWN ETIOLOGY (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 11/12/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fracture femur, right		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) HOME		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 11/19/69	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? SLIPPED ON THE FLOOR			
22. I certify that (I) (this hospital) attended the deceased from 11-19-69 19 69 to 12-5-69 19 69 that (I) (we) last saw the deceased alive on Dec. 5 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Victorino S. Yu, M.D.		23B. DATE SIGNED Dec. 5, 1969		23C. PHYSICIAN'S NAME (Type) VICTORINO S. YU, M.D.	
23D. ADDRESS U.M.H. MEMORIAL HOSPITAL		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12/8/69		24C. NAME of CEMETERY or CREMATORY Taylorsville Meth. Church. Cem.		24D. LOCATION (City, town, or county) (State) Taylorsville, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12095

CERTIFICATE OF DEATH

REG. NO.

69 12095

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SANFORD, NANCY BRADLEY

2. DATE AND HOUR OF DEATH

December 5th 1969

3:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

44 THE UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND.

A.A. Co. 5200

C. CITY OR TOWN

BALTIMORE ISLAND

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

SKYWATER DRIVE
GIBSON ISLAND

5. SEX

F

6. RACE

W

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

09-26-19

9. AGE (In years last birthday)

56

10. Under 1 Yr. Months: Days:

11. Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

OWN HOME

11. BIRTHPLACE (State or foreign country)

NEW YORK, N.Y.

12. CITIZEN OF WHAT COUNTRY?

AMERICAN / U.S.A.

13. FATHER'S NAME

L. WILLIAM BRADLEY

14. MOTHER'S MAIDEN NAME

MARY GREENE GEER

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

JOHN B. SANFORD

ADDRESS

(SAME)

18.

162.1 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Vital center failure.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

GI bleeding due to metastasis CA.

(C)

Lung CA & distant metastasis.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from December 3rd 19 69 to December 5th 19 69 that (I) (we) last saw the deceased alive on December 5th 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Tzen-chi Fan-chiang

DEGREE

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

December 5th 1969.

23C. PHYSICIAN'S NAME (Type)

TZEN-CHI FAN-CHIANG

DEGREE

23D. ADDRESS

Union Memorial Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/8/69

24C. NAME of CEMETERY or CREMATORY

Druid Ridge

24D. LOCATION (City, town, or county)

Dikesville, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

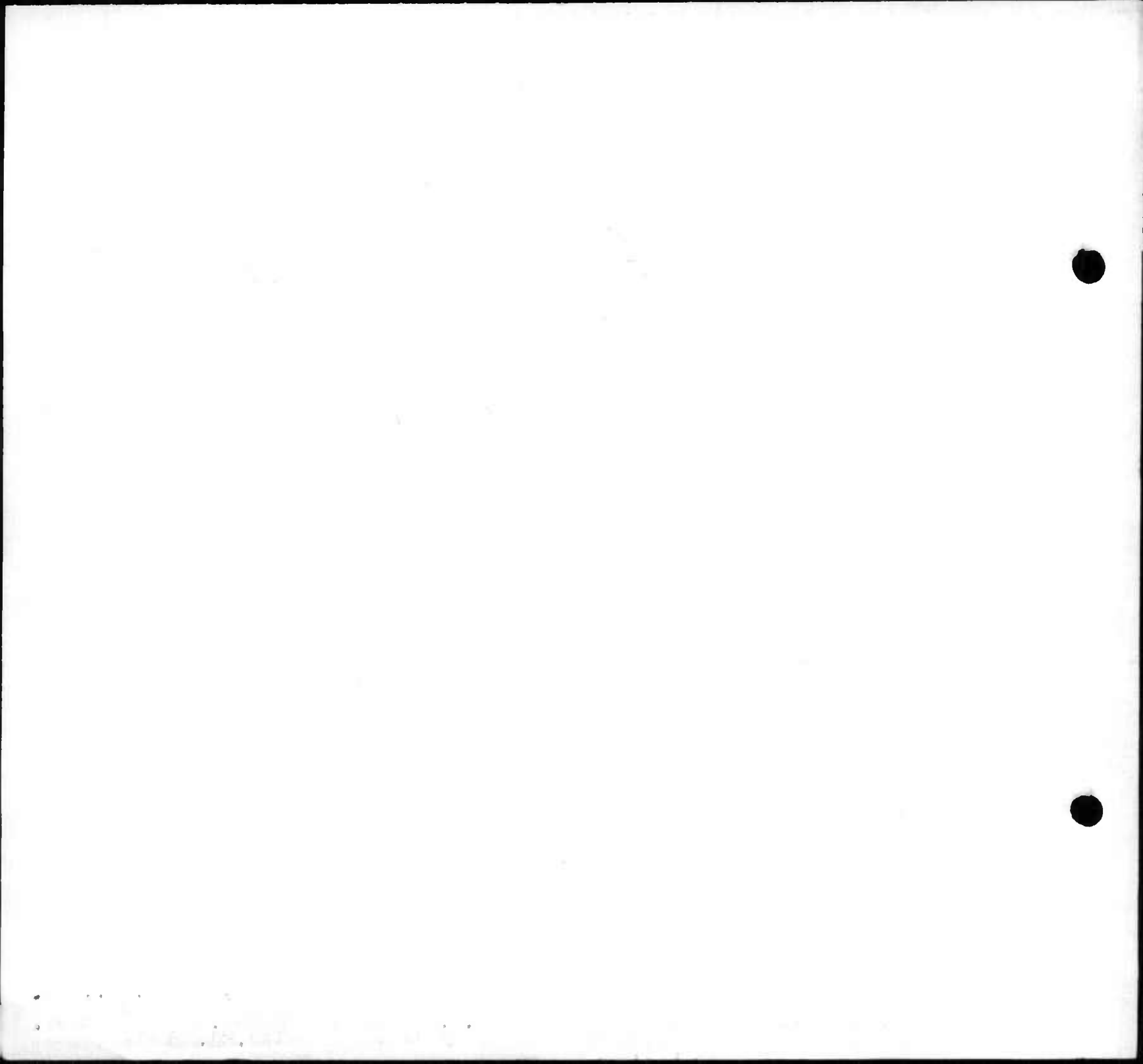
DEC 8 1969

25B. NAME OF REGISTRAR

John E. Fisher

25C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd. Balto. Md. 212



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12096		CERTIFICATE OF DEATH		REG. NO. 69 12096	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) BAILEY CORA IRENE		2. DATE AND HOUR OF DEATH December 5, 1969 6.15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2748		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 UNION MEMORIAL Hospital				E. STREET AND NUMBER 5604 WOODMONT AVENUE					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05-13-85	9. AGE (In years last birthday) 84	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN THOMAS BOSE				14. MOTHER'S MAIDEN NAME MARTHA (BOSE) RHEELING					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-01-6620		17. INFORMANT MRS. HAZEL F. CARSKI ADDRESS (SAME)			
18. 410.701250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (B) ARTERIOSCLEROTIC CARDIOVASCULAR Disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CONGESTIVE HEART FAILURE + PULMONARY EDEMA Diabetes Mellitus									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from December 3 1969 to December 5 1969 that (I) (we) last saw the deceased alive on December 5 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Miguel Karacuschansky M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED December 5, 1969			
23C. PHYSICIAN'S NAME (Type) Miguel KARACUSCHANSKY M.D. DEGREE				23D. ADDRESS UNION MEMORIAL Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-69		24C. NAME of CEMETERY or CREMATORY Giesey Mem. Cemetery		24D. LOCATION (City, town, or county) (State) Shrewsbury Pa.			
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969				25B. NAME OF REGISTRAR Robert E. Taylor, R.D.		25C. FUNERAL DIRECTOR'S ADDRESS Sons Co. 4905 York Rd. Balto. Md. 21212			

1. The first part of the report is a general introduction to the subject of the study.

2. The second part of the report is a detailed description of the methods used in the study.

3. The third part of the report is a discussion of the results of the study.

4. The fourth part of the report is a conclusion and a list of references.

5. The fifth part of the report is a list of appendices.

6. The sixth part of the report is a list of figures and tables.

7. The seventh part of the report is a list of footnotes.

8. The eighth part of the report is a list of acknowledgments.

9. The ninth part of the report is a list of abbreviations.

10. The tenth part of the report is a list of symbols.

m-460

69 12097

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 12097

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

LUCY MILLER

2. DATE AND HOUR OF DEATH

12/4/69

12:25

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 EASTERN AVENUE

BALTIMORE, MARYLAND

#21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

332 SOUTH MONROE STREET

#21223

5. SEX

FEMALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12-13-31

9. AGE (in years
last birthday)

37

If Under 1 Yr.

Months: Days

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Restaurant

11. BIRTHPLACE (State or foreign country)

VIRGINIA

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

LEE HOPKINS

14. MOTHER'S MAIDEN NAME

FLORENCE

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: BALTIMORE CITY HOSPITALS
4940 EASTERN AVENUE

#21224

18.

427.21 + 303.2

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

ANOXIC ENCEPHALOPATHY

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

8 MONTHS

(B)

CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF:

8 MONTHS

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

CHRONIC ALCOHOLISM

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~HT~~ (this hospital) attended the deceased from 7/23 19 69 to 12/4 19 69
that ~~HT~~ (we) last saw the deceased alive on 12/4 19 69 and that in (my) ~~our~~ opinion death occurred on the date
and hour and from the causes stated above. (I) ~~we~~ (did) ~~did not~~ view the body after death.

23A. SIGNATURE

Dennis W. Bleakley M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/4/69

23C. PHYSICIAN'S
NAME (Type)

DENNIS BLEAKLEY M.D.

23D. ADDRESS

BCH 4940 Eastern Avenue #21224

24A. BURIAL, CREMATION,
REMOVAL (Specify)

24B. DATE

12/8/69

24C. NAME of CEMETERY or CREMATORY

S. Boston Ch. Cemetery, Va.

24D. LOCATION

(City, town, or county)

(State)

S. Boston, Virginia

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1969

25B. NAME OF REGISTRAR

J. B. E. Taylor, M.D.

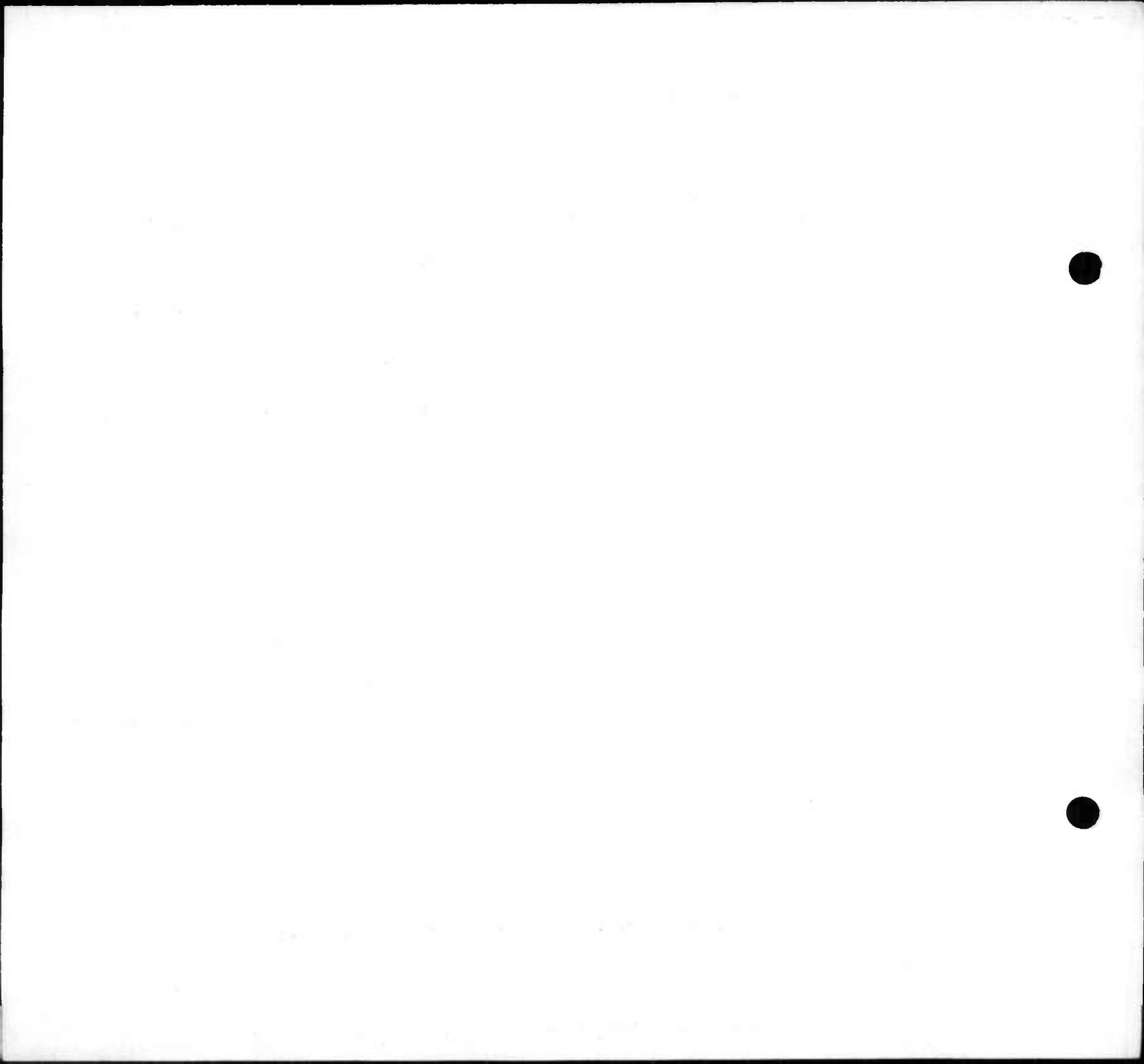
25C. FUNERAL DIRECTOR

J. B. E. Taylor, M.D. R. Schwalb F.H. Inc. Balto. Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

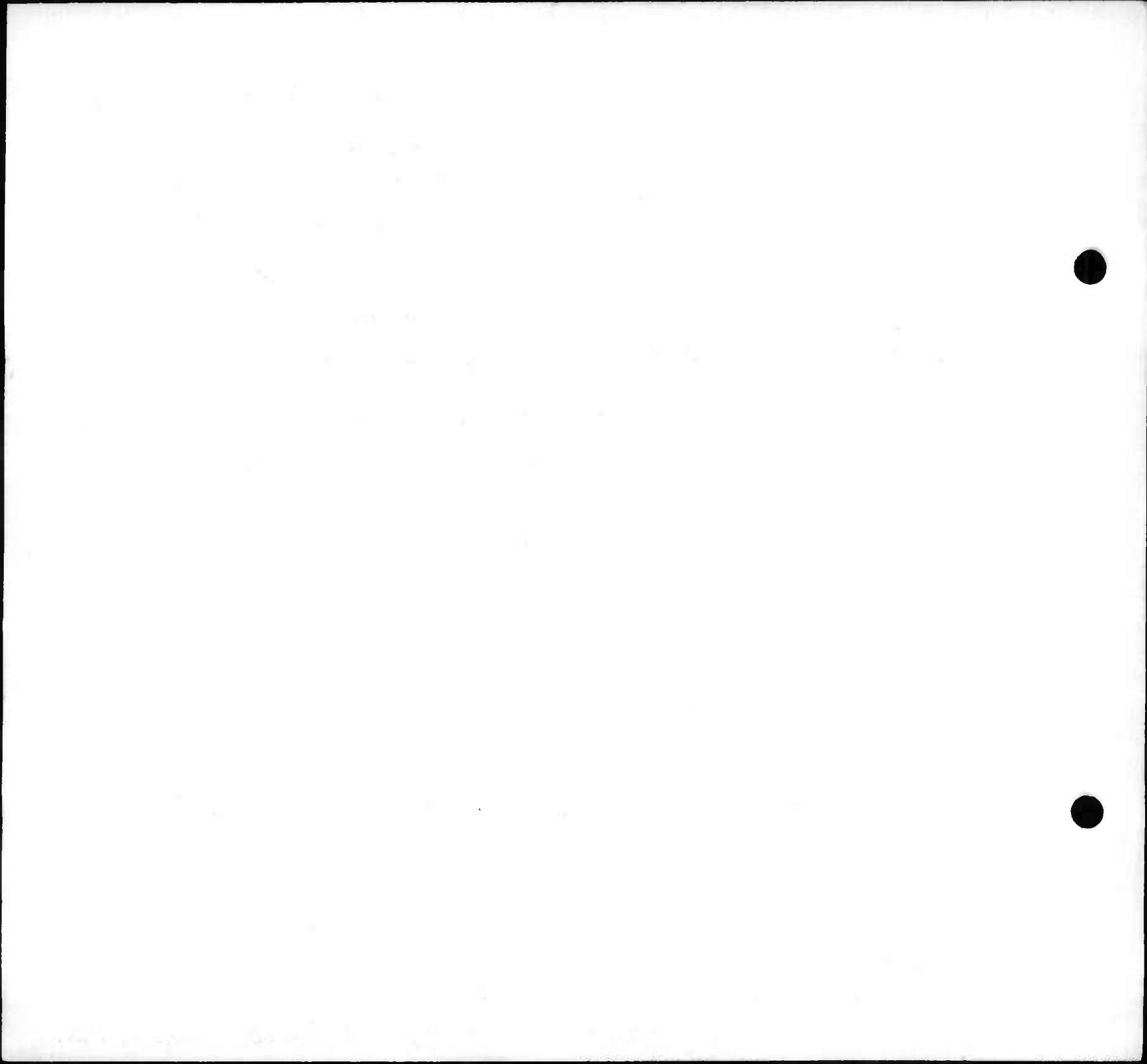
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

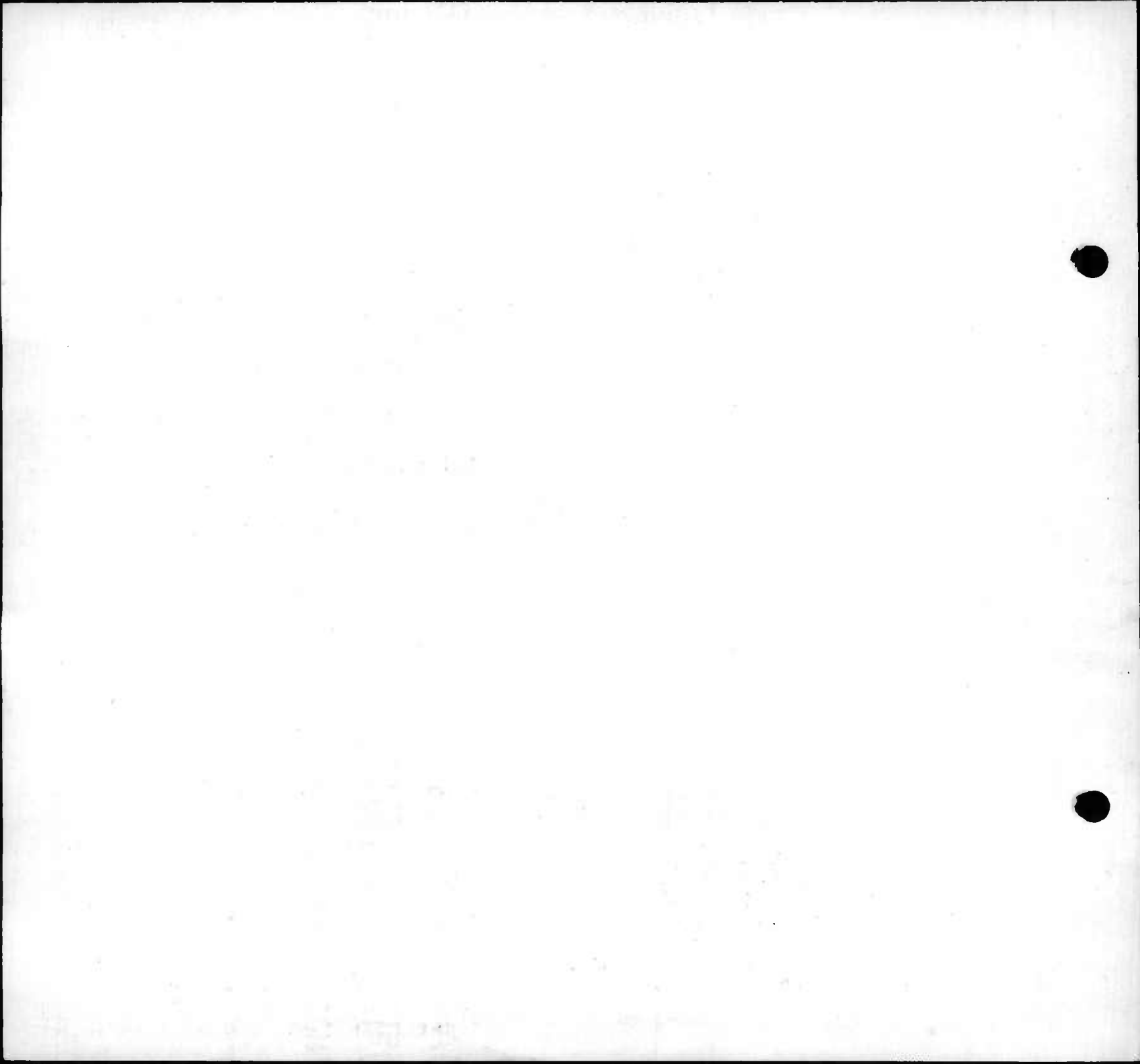
BALTIMORE CITY HEALTH DEPARTMENT				69 12098		CERTIFICATE OF DEATH		REG. NO. 69 12098	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				LOCHHEAD, MRS. LAURA		12-3-69 4:45 4:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				MARYLAND		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
BON SECOURS HOSPITAL						BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER		118 S. ADDISON STREET			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
F	W		9-1-1898	41	MARYLAND		UNITED STATES		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY					
Retired									
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
DANIEL H. KOHLERBURG				SARAH A. MURPHY					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
UNKNOWN				214-14-7327		WM. GARRISON 5621 Mayview Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH month			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 12/3 1969 to 12/3 1969 that (I) (we) last saw the deceased alive on 12/3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
M. Abbas M.D.				12-3-69					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
M. Abbas M.D.				Bon Secours Hosp.					
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		12/8/69		Louden Park Cem.		BALTO. Md.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 8 1969		Robert E. Taylor		George H. Schwab		BALTO. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Badly burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

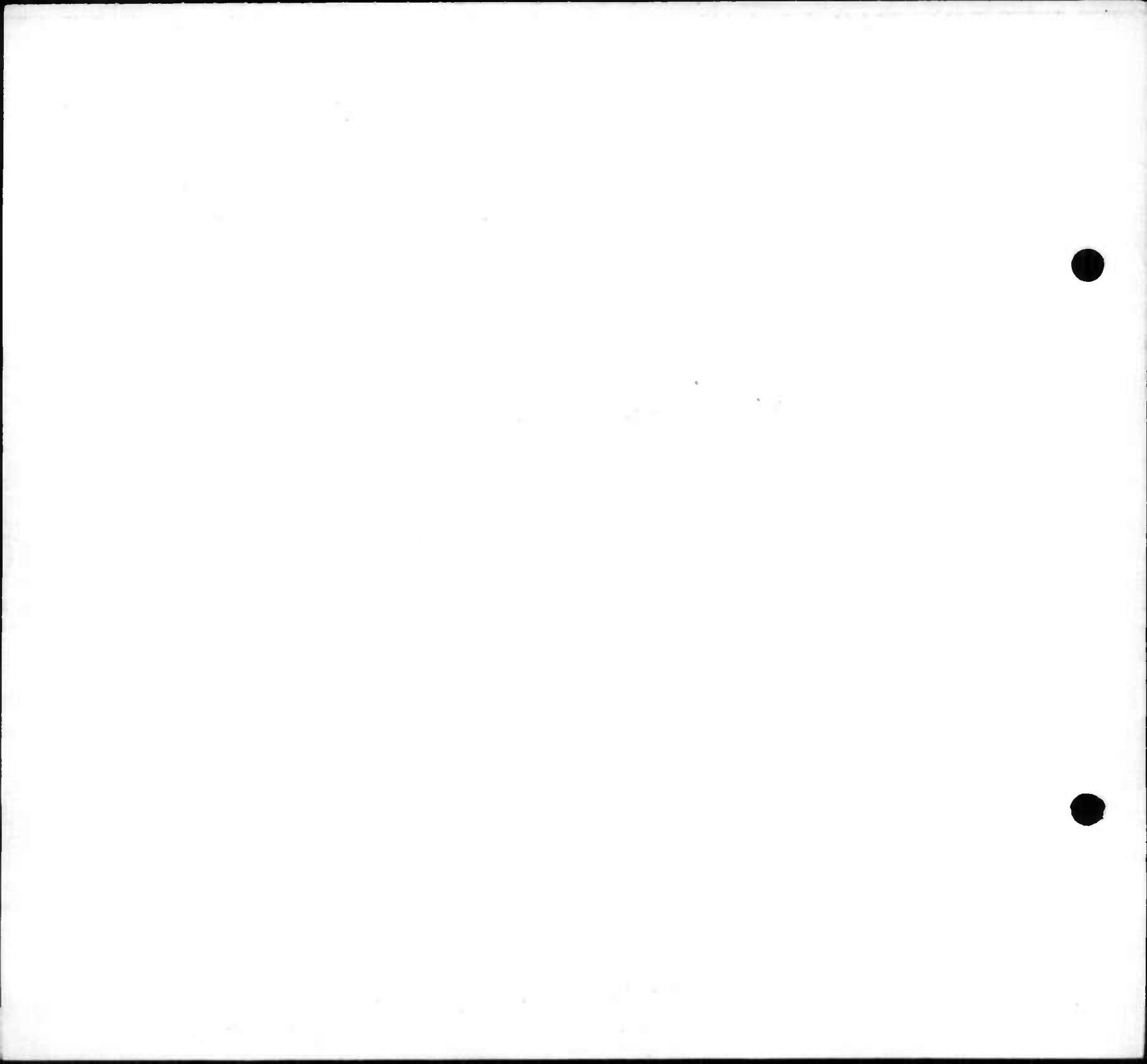
H-620		69 12099		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12099	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA HOBBS				2. DATE AND HOUR OF DEATH 12/5/1969 1 7⁰⁰ P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION KEY CIRCLE HOSPICE 1214 EUTAW STREET BALTO. MD. 21217				A. STATE MARYLAND		B. COUNTY 704	
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1818 HADISON AVE			
5. SEX F	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/3/1896	9. AGE (In years last birthday) 73	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CALVERT COUNTY, MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME ROBERT GROSS			
14. MOTHER'S MAIDEN NAME ANNA WALLACE				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 216-58-4859				17. INFORMANT MR. THOMAS HOBBS			
18. 309.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) circulatory failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. chronic brain syndrome				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: circulatory failure (B) DUE TO, OR AS A CONSEQUENCE OF: chronic brain syndrome (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-10-1969 to 12-5-1969 that (I) (we) last saw the deceased alive on 12-4-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-6-69	
23C. PHYSICIAN'S NAME (Type) R. RIGLER				23D. ADDRESS 1214 Eutaw Place			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-9-69		24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 461 W. BARRE ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

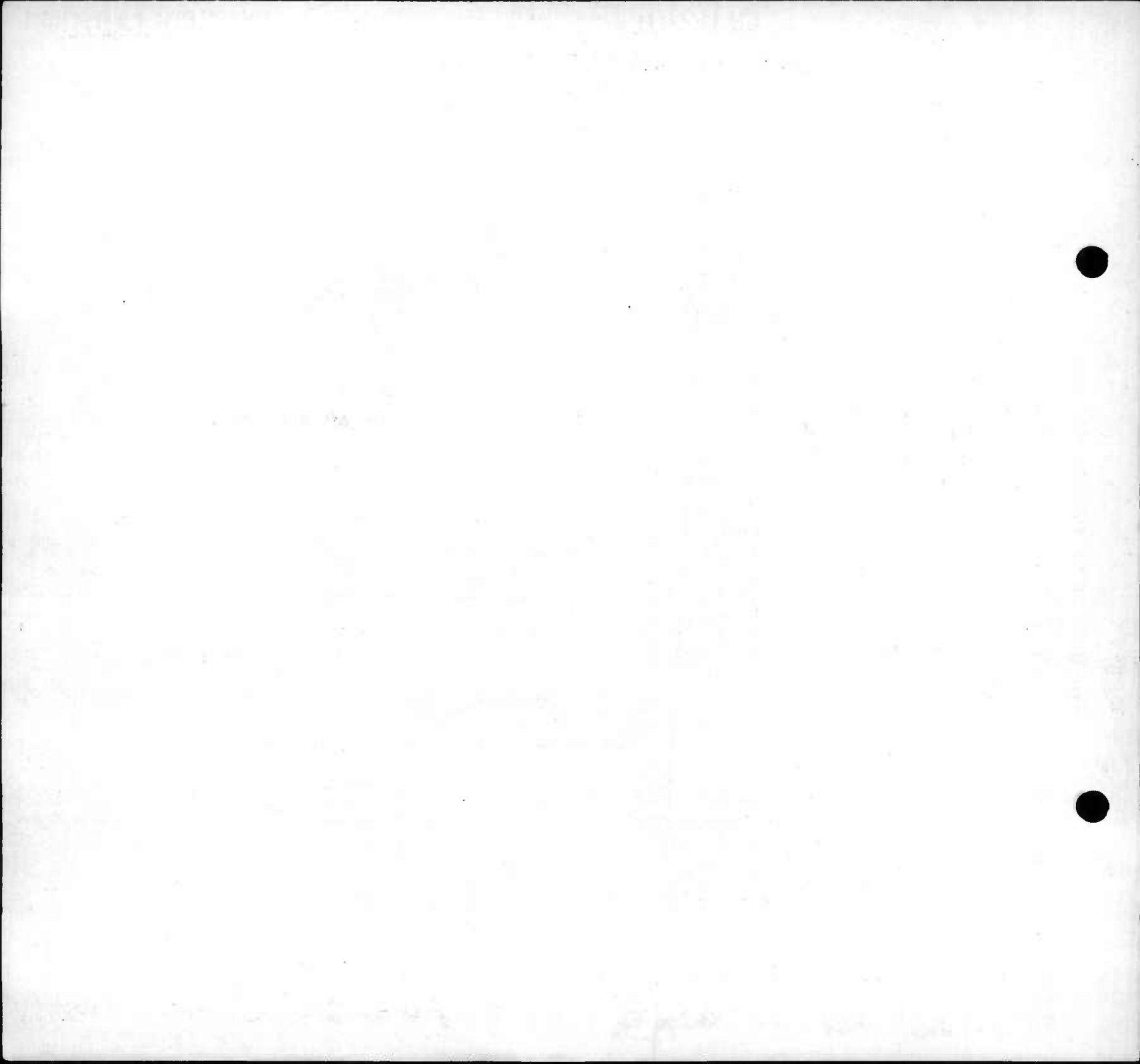
C-500		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12100	
BIRTH NO.		69 12100		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Can AWAY Melvin Thomas</u>		2. DATE AND HOUR OF DEATH <u>12/5/69</u> <u>11:00 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>38 UNIVERSITY HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1803</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>128 SCOTT ST.</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/2/29</u>	9. AGE (In years last birthday) <u>40</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINE OPERATOR</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SPICE CO.</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DAVID CONAWAY</u>			
14. MOTHER'S MAIDEN NAME <u>GRACE</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>DOWN</u> <u>2/6-20-44-36</u>			
16. SOCIAL SECURITY NO. <u>216-20-4436</u>		17. INFORMANT <u>PT - MOTHER</u>			
18. <u>5-35X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HYPOKALEMIC, HYPOCHLOREMIC ACIDOSIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>HEMORRHAGIC GASTRITIS</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12/5/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>RESPIRATORY DISTRESS</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>			
21D. TIME OF INJURY (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12/2</u> 19 <u>69</u> to <u>12/5</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/5</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Dennis Bleeg Jr.</u>		23B. DATE SIGNED <u>12/5/69</u>		23C. PHYSICIAN'S NAME (Type) <u>MD.</u>	
23D. ADDRESS <u>-</u>		23E. ADDRESS <u>-</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-10-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	
24D. LOCATION <u>Baltimore, Md.</u>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 8 1969</u>		25B. NAME OF REGISTRAR <u>John E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Charles G. Rice</u>	
25D. ADDRESS <u>661 W. Banne St.</u>		25E. ADDRESS <u>-</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-520		69 12101		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12101	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CORNELIUS D. MUNNICK				2. DATE AND HOUR OF DEATH Dec 7, 1969 Sun 2:30 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SOUTH BALTIMORE GENERAL HOSPITAL 43				A. STATE MD B. COUNTY 2301			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE 21230 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1406 CLARKSON ST.							
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 3, 1889	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BOX PACKER		10B. KIND OF BUSINESS OR INDUSTRY Box Cartage - Mfg.		11. BIRTHPLACE (State or foreign country) THE NETHERLANDS HOLLAND		12. CITIZEN OF WHAT COUNTRY? The NETHERLANDS HOLLAND	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 084-14-7990		17. INFORMANT MRS. CATHERINE D. MEDICUS 134 E. FORT AVE. Baltimore, Md. 21230		ADDRESS 685-0594	
18. CAUSE OF DEATH 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 4 DAYS ? YEARS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). MYOCARDIAL INFARCTION - OLD							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/17/69 to Dec 7, 1969, that (I) (we) last saw the deceased alive on Dec 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William Eric Sohr, M.D.				23B. DATE SIGNED 12/7/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS 4402 COLBORNE RD. BALTO, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 10, 1969		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md -	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Curtis E. Evans		25C. FUNERAL DIRECTOR Curtis E. Evans		ADDRESS 1400 S. CHARLES ST. BALTO, MD 21230	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

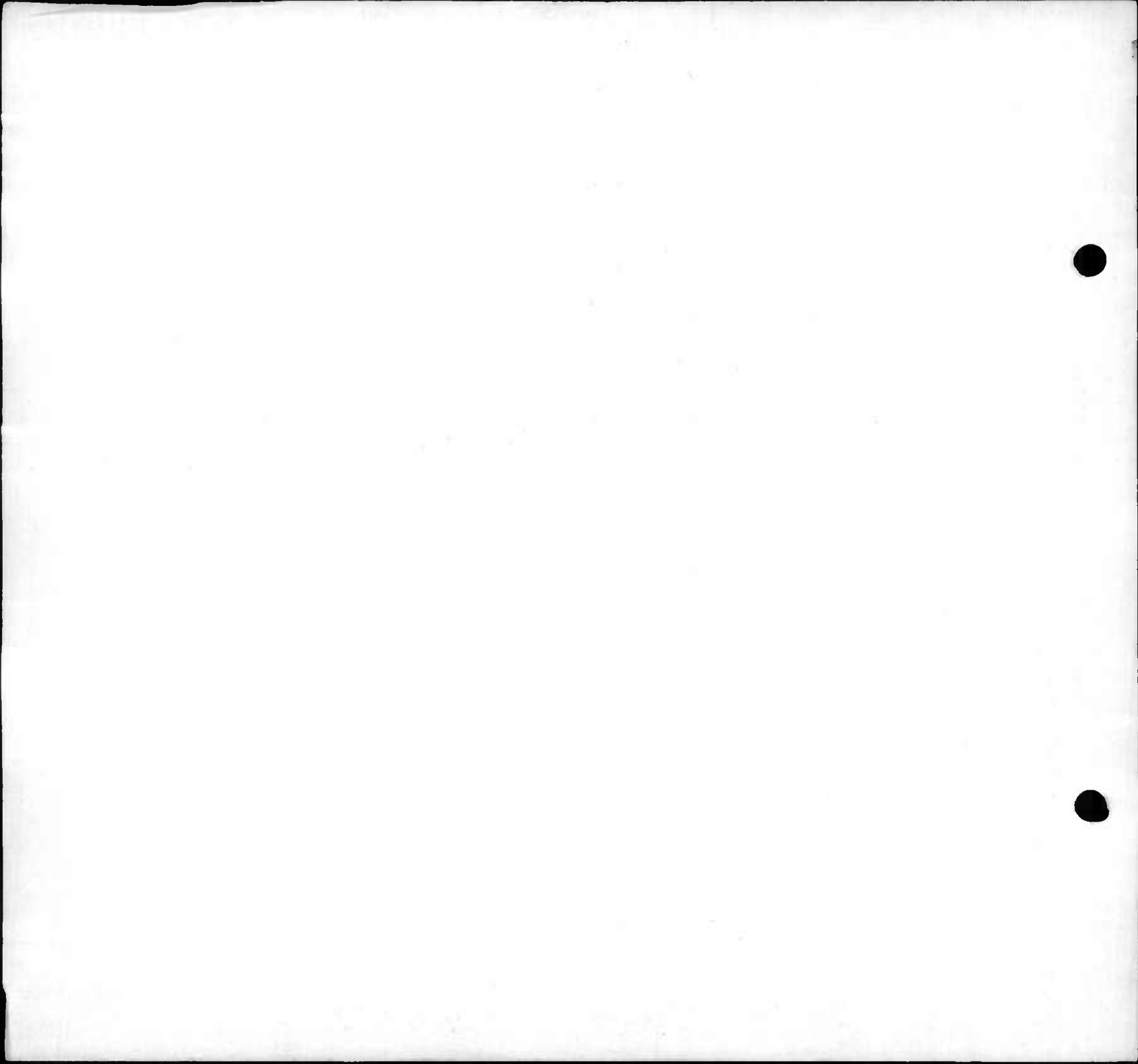
S-163		69 12102		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12102	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) JOHN F. SIFFORD (Frank)				2. DATE AND HOUR OF DEATH 12-2-69 9:23 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) GOOD SAMARITAN HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1506 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2775 W. NORTH AVE			
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-24-14	9. AGE (In years lost birthday) 55	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Charlotte, North Carolina		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Sifford				14. MOTHER'S MAIDEN NAME Ada Alexander			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-9201		17. INFORMANT Catherine Sifford		ADDRESS 2775 W. North Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 250.9 I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Uremia ~1 yr. (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetic Nephropathy ~10 yrs. (C) Diabetic ret.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 21 19 69 to Dec. 2 19 69, that (I) (we) lost saw the deceased alive on Dec. 2, 19 69 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Leonard R. J. H.D. OEGREE				23B. DATE SIGNED 12-2-69		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-5-69		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Robert E. Sifford		25C. FUNERAL DIRECTOR C. S. Phillips		ADDRESS 1727 N. W. Street	

PA-PA-61

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12103	
BIRTH NO. H-125		69 12103 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) MARIAN L. HOPKINS (Laurel)		2. DATE AND HOUR OF DEATH 12-1-1969 5-15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1542 N. Payson St.	
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9/17/1945
9. AGE (In years last birthday) 24 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Cramer Vaughn	
14. MOTHER'S MAIDEN NAME Chlorine Grant		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 218-36-7594		17. INFORMANT Robert Hopkins ADDRESS 4921	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 485X BRONCHOPNEUMONIA, ACUTE		INTERVAL BETWEEN ONSET AND DEATH 9 months	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO (B) DUE TO (C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Disseminated lymph erythematous	
19A. DATE OF OPERATION 2	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) Yes	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-20 19 69 to 12-1 19 69 , that (I) (we) last saw the deceased alive on 12-1 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE M. S. AL-IBRAHIM M.D.		23B. DATE SIGNED 12-1-1969	
23C. PHYSICIAN'S NAME (Type) M. S. AL-IBRAHIM M.D.		23D. ADDRESS Md. Gen. Hospital.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-5-69	24C. NAME OF CEMETERY OR CREMATORY Carver Mem PK	24D. LOCATION (City, town, or county) (State) Laurel Md
25A. DATE REC'D BY HEALTH DEPT. DEC 8 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Colington & Phillips		ADDRESS 1727 N. Monmouth St	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-500

69 12104

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 12104

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

LOUISE JUNE (Grant)

2. DATE AND HOUR OF DEATH

DEC 6, 1969 8:00 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)Baltimore City Hospitals
4940 Eastern Ave.
Baltimore Md. 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

1607

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3012 Littleton Rd. 21216 007

5. SEX

Female

6. RACE

Negro

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12-2-20

9. AGE (in years
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Grant

14. MOTHER'S MAIDEN NAME

Sarah Ann Linkins

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

249-34-7521

17. INFORMANT

4940 Eastern Ave.

ADDRESS

BCH: Records Baltimore, Md. 21224

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

?

?

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

12-4-69

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

CARCINOMA STOMACH

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?
(If in Baltimore City, give exact location)21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11-18 19 69 to 12-6 19 69
that (I) (we) last saw the deceased alive on 12-6 19 69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W.E. Powers Jr. M.D.

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12-6-69

23C. PHYSICIAN'S
NAME (Type)

W.E. Powers Jr. M.D.

23D. ADDRESS

Baltimore City Hospitals
4940 Eastern Ave. Baltimore, Md. 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

Removal

24B. DATE

12-8-69

24C. NAME OF CEMETERY OR CREMATORY

Fair Bridges

24D. LOCATION

(City, town or county)

(State)

Sumter Co. South Carolina

25A. DATE REC'D BY HEALTH DEPT

DEC 8 1969

25B. NAME OF REGISTRAR

John E. Taylor

25C. FUNERAL DIRECTOR

Wilmington Phillips

ADDRESS

1727 N. Mount St.

Lytleton Rd.

L-560

69 12105

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12105

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

PERCY LANIER JR.

2. DATE
OF
DEATHKnown ☒
Estimated ☐

Month

Day

Year

Hour

December 3, 1969

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital

(DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

December 3, 1969

2:10 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

15 47

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10-4-1949

10. AGE (In years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2311 N. Dukeland Street

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Percy E. Lanier Sr.

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Matilda

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

18. INFORMANT

Matilda Lanier

ADDRESS

Same

19.

E 9651 X

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Gunshot wound of chest
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Store

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

736 N. Monroe Street

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

12-3-69

1:30 P.m.

22E. INJURY OCCURRED
WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Shot while attempting hold-up of store

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-8-69

24C. NAME OF CEMETERY or CREMATORY

Baltimore National

24D. LOCATION (City, town, or county)

Baltimore

(State)

MD.

25A. DATE REC'D BY HEALTH DEPT.

DEC 8 1969

25B. NAME OF REGISTRAR

Charles S. Springate

25C. FUNERAL DIRECTOR

Wm. J. Sullivan

ADDRESS

1727 N. Mount St.

10-1-1941

10-1-1941

10-1-1941

ACAD. DIV. 10-1-1941

10-1-1941

10-1-1941

10-1-1941

10-1-1941

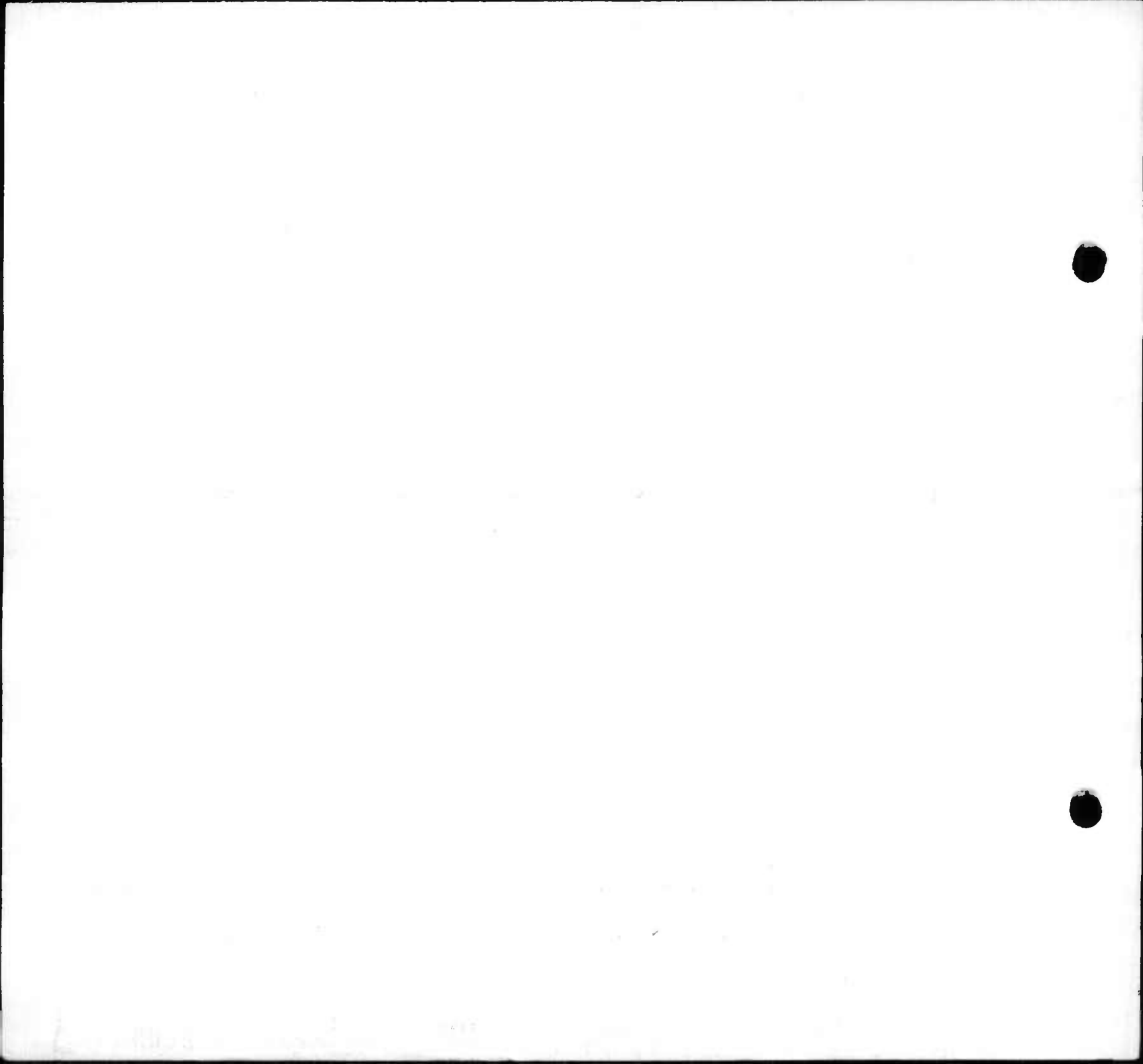
10-1-1941

10-1-1941

FUNERAL DIRECTOR: IMPORTANT

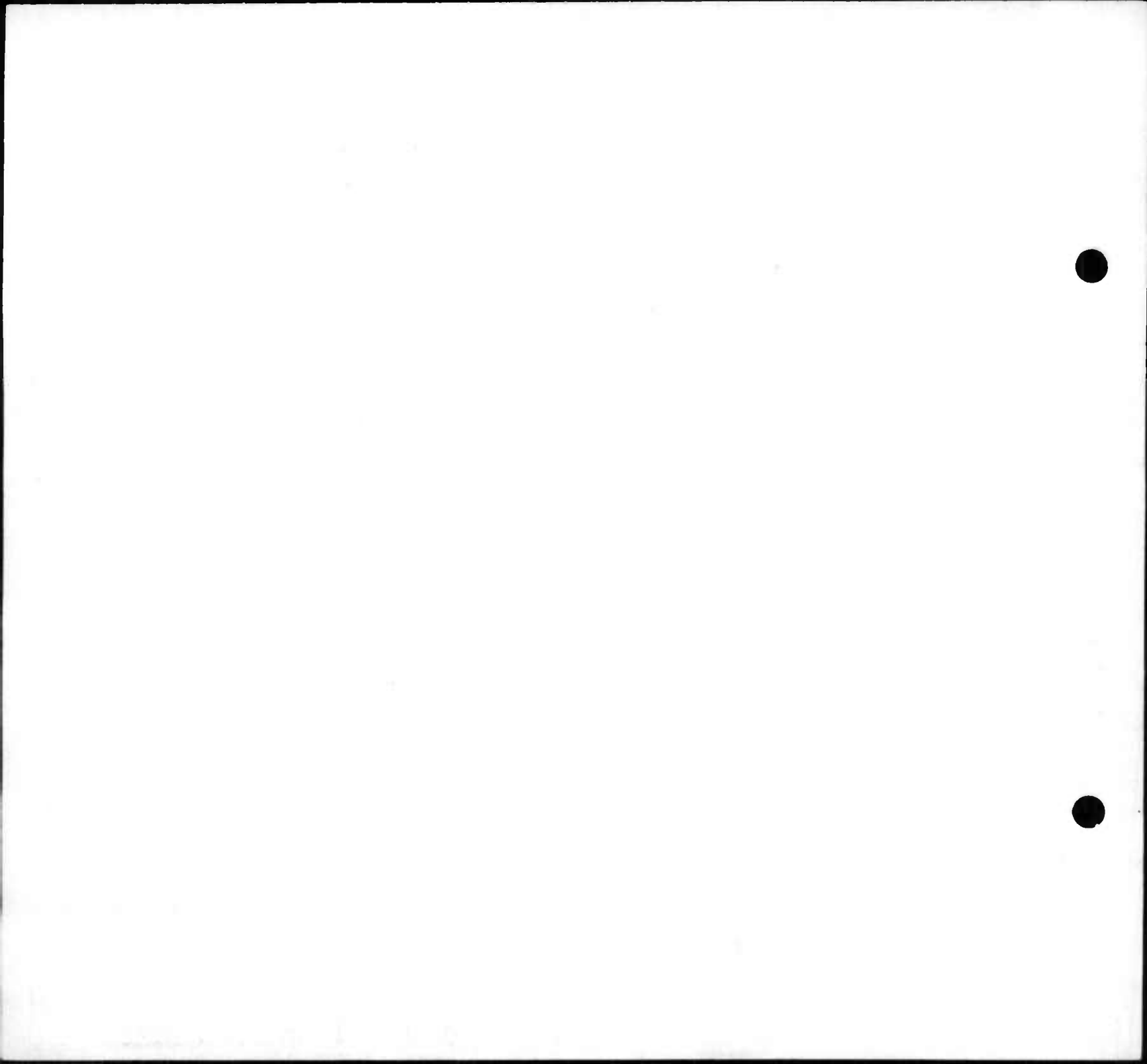
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-355 BIRTH NO. <u>69-19523</u>		69 12106 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>69 12106</u>	
1. NAME OF DECEASED (Type or Print) EDMOND, BABY BOY			2. DATE AND HOUR OF DEATH 10-22-69 3:10 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Sinai Hospital of Baltimore, Inc.			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY 27 59 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1316 E. Coldspring		
5. SEX M	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-69	9. AGE (In years last birthday) 3	10. Under 1 Yr. Months: Days: 3
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN		14. MOTHER'S MAIDEN NAME LYDIA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 776.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Severe hyaline membrane disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Prematurity			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Johnny Eufemio M.D.		23B. DATE SIGNED 10-22-69		23C. PHYSICIAN'S NAME (Type) JOHNNY EUFEMIO M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 10-4-69		24C. NAME OF CEMETERY or CREMATORY Sinai Hospital of Baltimore	
24D. LOCATION (City, town, or county)		24E. LOCATION (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

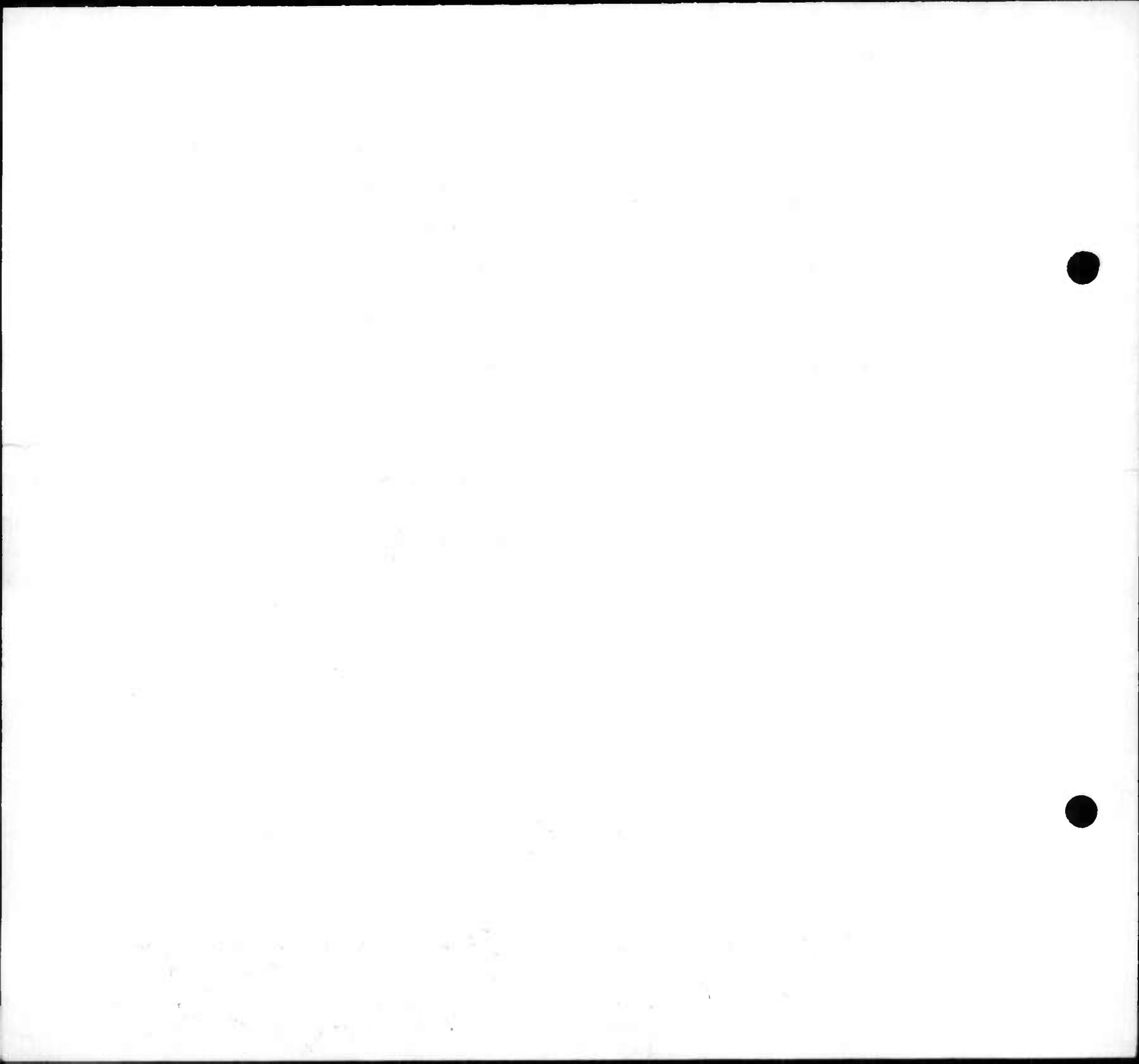
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12107	
L-428 69 12107				CERTIFICATE OF DEATH	
BIRTH NO. 69 20664		1. NAME OF DECEASED (Type or Print) <i>Baby Girl Lelis</i>		2. DATE AND HOUR OF DEATH <i>11-10-69 at 3:15 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>42 SINDI Hospital</i>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Balto, Md.</i> B. COUNTY <i>2717</i>		
5. SEX <i>F</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		8. DATE OF BIRTH <i>11-7-69</i>	
13. FATHER'S NAME <i>Roberto Lelis</i>		14. MOTHER'S MAIDEN NAME <i>Consolacion Garcia</i>		9. AGE (In years last birthday) <i>2</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>	
17. INFORMANT <i>SINDI Hospital</i>		ADDRESS <i>Balto, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
18. <i>775-21</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE <i>Prematurity of Respiratory system</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Prematurity</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11-7-69</i> 19 to <i>11-10-1969</i> that (I) (we) last saw the deceased alive on <i>11/10</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Choyan T. Lee, M.D.</i>		23B. DATE SIGNED <i>10-10-69</i>		23C. PHYSICIAN'S NAME (Type) <i>CHOYAN T. LEE, M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12-4-69</i>		24C. NAME OF CEMETERY or CREMATORY	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 9 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>MORTUARY SERVICE - BCHD</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>E-425 69 12108</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12108</p>	
<p>BIRTH NO. 69-18111</p>		<p>2. DATE AND HOUR OF DEATH Oct. 2, 1969 5:40 PM</p>	
<p>1. NAME OF DECEASED (Type or Print) Baby Bry E. Jackson</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE X 1967 Pentwood Rd B. COUNTY 21212 2739</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4251DA Hospital of Baltimore, Inc.</p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>5. SEX M 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 9-30-69 9. AGE (in years last birthday) 39 10. If Under 1 Yr. Months: Days: 39 25 11. If Under 24 Hrs. Hours: Min. 39 25</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) U.S.A.</p>		<p>12. CITIZEN OF WHAT COUNTRY?</p>	
<p>13. FATHER'S NAME X Milton</p>		<p>14. MOTHER'S MAIDEN NAME X Sallie</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT</p>		<p>ADDRESS</p>	
<p>18. 776.21 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE Respiratory Distress DUE TO, OR AS A CONSEQUENCE OF: Sudden gts. bld</p> <p>(B) Prematurity DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 9-30-69 19 to 10-2-69 19 that (I) (we) last saw the deceased alive on 10-2-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Choyan T. Lee, M.D.</p>		<p>23B. DATE SIGNED 10-2-69</p>	
<p>23C. PHYSICIAN'S NAME (Type) Choyan T. Lee, M.D.</p>		<p>23D. ADDRESS SAUNA Hospital of Baltimore</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>		<p>24B. DATE 10-4-69</p>	
<p>24C. NAME OF CEMETERY OR ANATOMY</p>		<p>24D. LOCATION (City, town, or county) (State)</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969</p>		<p>25B. NAME OF REGISTRAR John E. Taylor, M.D.</p>	
<p>25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCD</p>		<p>25D. ADDRESS</p>	



FUNERAL DIRECTOR: IMPORTANT

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<p>69 12109</p> <p>CERTIFICATE OF DEATH</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>REG. NO. 69 12109</p>	
<p>1. NAME OF DECEASED (Type or Print) <i>Baby Girl Toler</i></p>		<p>2. DATE AND HOUR OF DEATH <i>11/3/69 11:15 A.M.</i></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Senai Hospital of Baltimore</i></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2716</i></p> <p>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <i>2812 Oakford Ave #15</i></p>	
<p>5. SEX <i>F</i></p>	<p>6. RACE <i>N</i></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <i>11/3/69</i></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	<p>11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i></p>
<p>13. FATHER'S NAME <i>Jacob Toler</i></p>		<p>14. MOTHER'S MAIDEN NAME <i>Scott, Elaine</i></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service</p>		<p>16. SOCIAL SECURITY NO.</p>	<p>17. INFORMANT ADDRESS</p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>038.9 I Prematurity</i></p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Sepsis</i></p>		<p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Prematurity</i></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Sepsis</i></p> <p>(C) _____</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <i>0</i></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/> No</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <i>11/3/69</i> to <i>11/3/69</i>, that (I) (we) lost saw the deceased alive on <i>11/3/69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>Todd Gladstone, M.D.</i></p>		<p>23B. DATE SIGNED <i>11/3/69</i></p>	<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>
<p>23C. PHYSICIAN'S NAME (Type) <i>Todd Gladstone, M.D.</i></p>		<p>23D. ADDRESS <i>Senai Hospital of Baltimore</i></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>	<p>24B. DATE <i>12-4-69</i></p>	<p>24C. NAME of CEMETERY or CREMATORY <i>ANATOMY BOARD OF MARYLAND</i></p>	<p>24D. LOCATION <i>UNIVERSITY MEDICAL SCHOOL</i></p>
<p>25A. DATE RECEIVED BY HEALTH DEPARTMENT <i>DEC 9 1969</i></p>		<p>25B. NAME OF REGISTRAR <i>John E. Kelly</i></p>	<p>25C. FUNERAL DIRECTOR ADDRESS <i>MORTUARY SERVICE - BCHD</i></p>

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

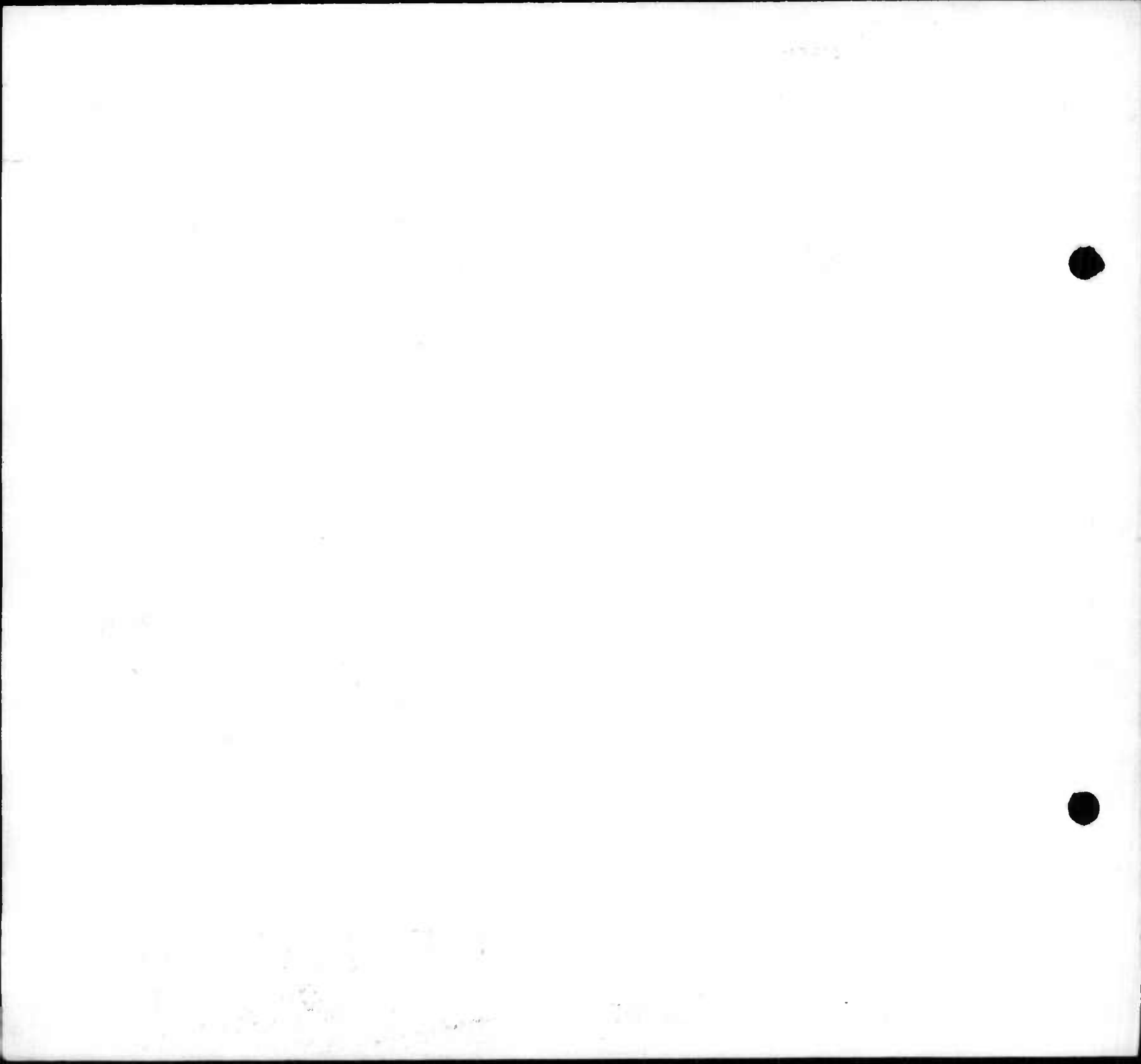
T-621 BIRTH NO. 69-18710		69 12110		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12110		4	
1. NAME OF DECEASED (Type or Print) BABY BOY TRESVANT				2. DATE AND HOUR OF DEATH 10-11-69 6:25 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSP OF BALTIMORE, INC.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5409 Princeton Ave #15					
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-11-69		9. AGE (in years last birthday) 10: 56		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NB		10B. KIND OF BUSINESS OR INDUSTRY NB		11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ALAN L. ROBINSON				14. MOTHER'S MAIDEN NAME VALERIE TREZEVANT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT VALERIE TREZEVANT		ADDRESS 5409 Princeton Ave #15			
18. 777X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE PREMATURITY DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs 30 min			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 10-11-1969 to 10-11-1969 that (1) (we) last saw the deceased alive on 10-11-1969 and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Edward N. Zisman M.D.				23B. DATE SIGNED 10-11-69		23C. PHYSICIAN'S NAME (Type) EDWARD N. ZISMAN			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-4-69		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION		24E. CITY, TOWN OR COUNTY (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD		25D. ADDRESS			

5409 Price out
27-88

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-500 69 12111 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12111
BIRTH NO. <u>69-21830</u>		2. DATE AND HOUR OF DEATH <u>11/28/69</u> <u>8:45 P.M.</u>
1. NAME OF DECEASED (Type or Print) <u>Baby Girl Cain</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO.</u>
3. PLACE IN BALTIMORE MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Church Home & Hosp.</u>		5. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
5. SEX <u>F</u> 6. RACE <u>Colo.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/28/69</u> 9. AGE (In years lost birthday) <u>0</u> If Under 1 Yr. Months: Days: Hours: Min. <u>6</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ROGER CAIN</u>		14. MOTHER'S MAIDEN NAME <u>Virginia ?</u>
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u> 16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>—</u> ADDRESS <u>—</u>
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 45%;"> (A) IMMEDIATE CAUSE <u>Respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) Prematurity DUE TO, OR AS A CONSEQUENCE OF: (C) — </div> <div style="width: 10%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </div> </div>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION <u>—</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>✓</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>—</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u> 21E. INJURY OCCURRED White Al <input type="checkbox"/> Not White <input type="checkbox"/> Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>
22. I certify that (I) (this hospital) attended the deceased from <u>Nov. 28</u> <u>1969</u> to <u>Nov. 28</u> <u>1969</u> that (I) (we) lost saw the deceased alive on <u>Nov. 28</u> <u>1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE <u>Corazon Z. Vergara, M.D.</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>11/28/69</u>
23C. PHYSICIAN'S NAME (Type) <u>CORAZON VERGARA</u>		23D. ADDRESS <u>Church Home & Hosp.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>—</u> 24B. DATE <u>12-4-69</u>		24C. NAME of CEMETERY or CREMATOR <u>—</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>
ANATOMY BOARD OF MARYLAND UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCHD		



F-300

69 12112

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12112

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) THOMAS FOOTE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1827 Raynor Avenue (DOA)		3. DATE PRONOUNCED DEAD Month Day Year November 12, 1969 Hour 2:27 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (in years last birthday) 57		E. STREET AND NUMBER 1827 Raynor Avenue	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary Tuberculosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 11/12/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 11-25-69	
24C. NAME OF CEMETERY or		24D. NAME OF CEMETERY or	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Raynor, M.D.	
25C. FUNERAL DIRECTOR		25D. ADDRESS	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

UNIVERSITY OF CALIFORNIA LIBRARY
MEDICAL CENTER
LOS ANGELES, CALIF.

H-400

69 12113

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12113

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

DEILMO HALL

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
10 16 69 8:14 p.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital D.O.A.

3. DATE PRONOUNCED DEAD Month Day Year Hour
October 16, 1969 8:14 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY

Maryland

170.3

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

10. AGE (In years last birthday)

58

11. Under 1 Yr. 12 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

1220 Argyle Ave.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Fracture of the neck
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?

1220 Argyle Ave.

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

10 16 69 7:40 a.m.

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject fell down stairs

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

October 17, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

CREMATED

24B. DATE

11-25-69

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 9 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

ACADEMY BOND

THIS BOND IS

VALID FOR

1000

1000

1000

1000

C-234 69 12114 BALTIMORE CITY HEALTH DEPARTMENT
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 12114

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOSEPH G. COSTELLA		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION CHURCH HOME AND HOSPITAL (DOA) (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour October 31, 1969 2:40 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 202	
9. DATE OF BIRTH		10. AGE (In years lost birthday) 71 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT		ADDRESS	

19. 412 + 011.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.	CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
	(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
	(B) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Pulmonary Tuberculosis	

20A. DATE OF OPERATION 2	20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21. AUTOPSY? (Yes or No) yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	22F. HOW DID INJURY OCCUR?

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE *Ronald N. Kornblum* M.D.
 EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.**

CHIEF MEDICAL EXAMINER ☐
 ASSISTANT MEDICAL EXAMINER ☒
 ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED **11/1/69**

24A. BURIAL CREMATION, REMOVAL (Specify) Cremated	24B. DATE 11-25-69	24C. NAME OF BOARD OF MARYLAND ANATOMY BOARD OF MARYLAND	24D. LOCATION (City, town, or county) (State) BALTIMORE MARYLAND
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969	25B. NAME OF JOHN E. FOLEY, M.D.	25C. MEDICAL DIRECTOR UNIVERSITY MEDICAL SCHOOL	ADDRESS MORTUARY SERVICE - BCHD

General 4-22-61
UNITED STATES
NATIONAL BOARD OF HEALTH
WASHINGTON, D.C.

WILFRED
VALLEY

S-536

69 12115

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12115

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Basil Saunders

2. DATE
OF
DEATHKnown ☐

Month

Day

Year

Hour

M.

Estimated ☐

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

540 Mission Court

3. DATE

PRONOUNCED DEAD

Month

Day

Year

Hour

10

26

69

10:30 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1403

6. SEX

Male

7. RACE

Negro

B. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

May 9, 1921

10. AGE (In years
lost birthday)

48

11. Under 1 Yr. 12 Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

540 Mission Court

11. BIRTHPLACE (State or foreign country)

Balto., Maryland

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Richard Saunders

14. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Body & Pender Man

14B. KIND OF BUSINESS OR INDUSTRY

Auto Repair

15. MOTHER'S MAIDEN NAME

Daisy Bell Wilkerson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W.W. II

17. SOCIAL
SECURITY NO.

712-12-5106

18. INFORMANT

ADDRESS

Brenda Saunders, Wife, 1104 N. Mount St.

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Fatty metamorphosis of the liver

(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

10-27-69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Cremated

24B. DATE

11-25-69

24C. NAME OF REGISTERED CREMATOR

24D. LOCATION (City, town or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 9 1969

25B. NAME OF REGISTRAR

J. E. Fisher, M.D.

25C. NAME OF FUNERAL HOME OR ADDRESS

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

MORTUARY SERVICE - BCHD

12/16/69 - Birth certificate of deceased - C-10269. D.B. 5/9/1921.

Correction form from funeral director.

L.B.C.

12/16/69

5/9/21

VALLEY FOR

CHURCH

H-550

69 12116 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12116

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert Heenan		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 18 69 12:30a M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 401 W. Pratt St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 18 69 12:30 a.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Michigan B. COUNTY V-19	
9. DATE OF BIRTH		10. AGE (In years last birthday) 45 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
15. MOTHER'S MAIDEN NAME		18. INFORMANT ADDRESS	
19. 493X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) BRONCHIAL ASTHMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchial asthma (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 10/18/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 11-25-69	
24C. NAME OF CEMETERY OR CREMATORIAL		24D. NAME OF CEMETERY OR CREMATORIAL	
25A. DATE RECEIVED BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR W. E. Spitz	
25C. NAME OF REGISTRAR		25D. NAME OF REGISTRAR	

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
MORTUARY SERVICE - BCHD

Quantity

11-52-63

Handwritten signature

VALLEY FORGE

VALLEY FORGE

R-500

69 12117

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12117

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Patrick Ryan		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 10 18 69 2:15 p. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 511 Park Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 10 18 69 2:15 p. M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1102	
9. DATE OF BIRTH		10. AGE (In years last birthday) 35-40	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS	
19. 571.81 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner <input type="checkbox"/> DATE SIGNED 10/18/69 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 11-25-69	
24C. NAME OF CEMETERY or CREMATORY ANATOMY BOARD OF MARYLAND		24D. LOCATION (City, town, or vicinity) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
UNIVERSITY MEDICAL SCHOOL MORTUARY SERVICE - BCND			

VALLEY POLICE
CENTRAL OFFICE

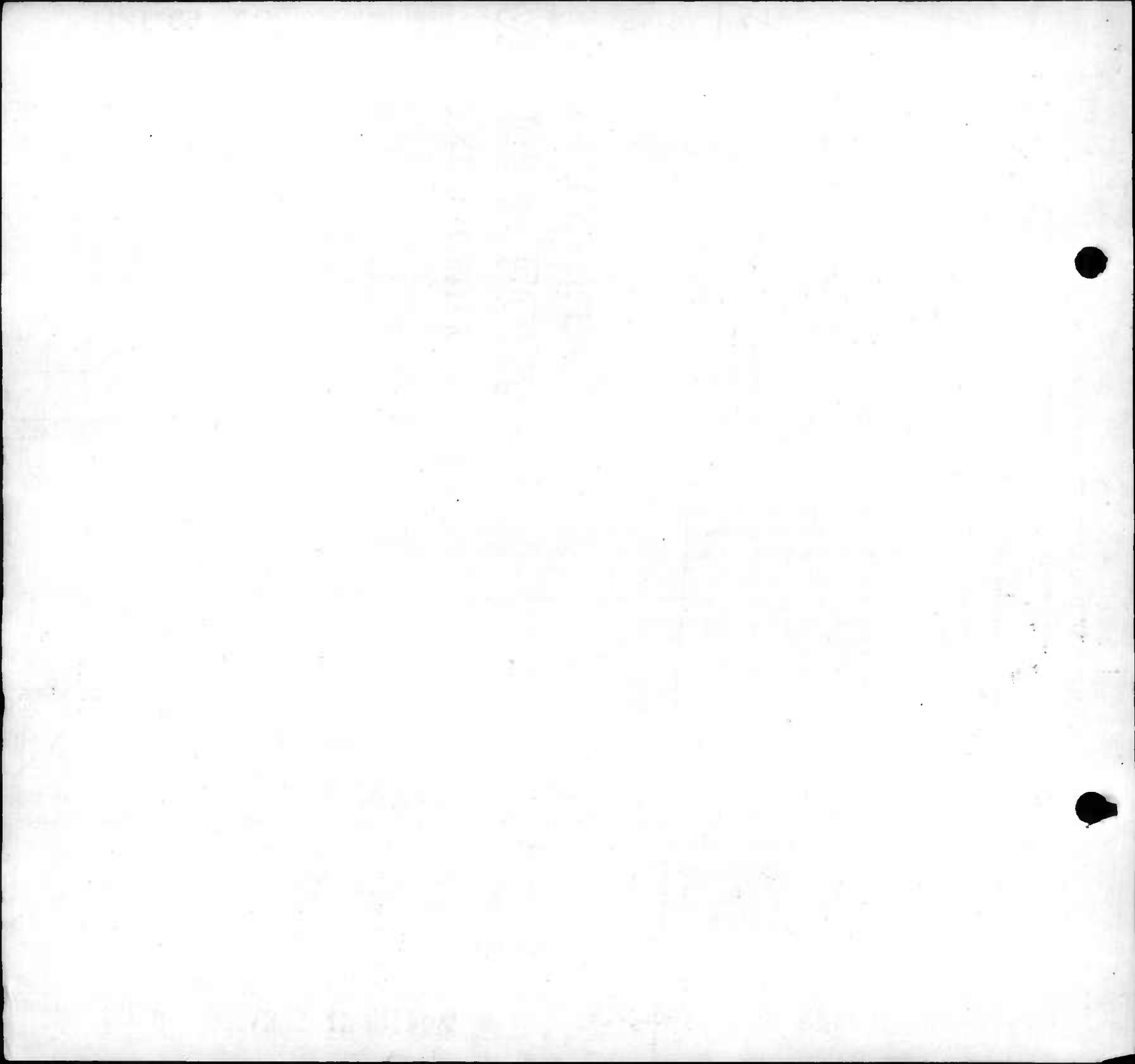
Warrant for
Arrest

11-25-61
Criminal

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

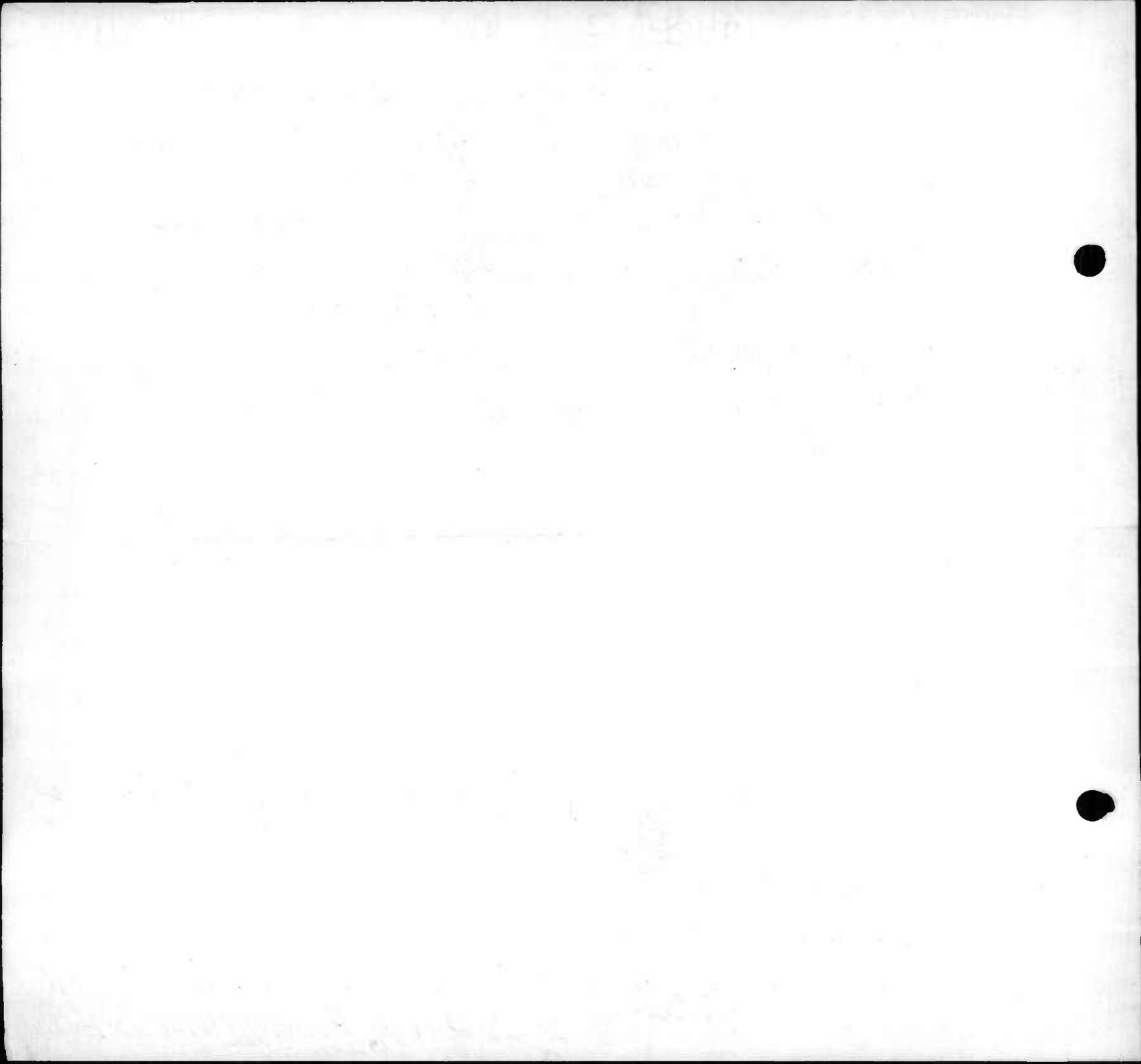
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12118	
69 12118				CERTIFICATE OF DEATH	
BIRTH NO. <u>R-100</u>					
1. NAME OF DECEASED (Type or Print) <u>ANNA RUF</u>			2. DATE AND HOUR OF DEATH <u>11/28/69</u> <u>855 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>43</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>HARFORD</u> C. CITY OR TOWN <u>HYDES</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>Box 110</u> <u>HARFORD ROAD</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-10-93</u>	9. AGE (In years last birthday) <u>76</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <u>4 10 9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>MYOCARDIAL INFARCTION</u> <u>2 Hrs</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>0</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (<u>this hospital</u>) attended the deceased from <u>11/29</u> 19 <u>69</u> to <u>11/29</u> 19 <u>69</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>11/29</u> 19 <u>69</u> and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.					
23A. SIGNATURE <u>Coleen C. Heinitz</u>				23B. DATE SIGNED <u>11/29/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>COLEEN C. HEINITZ</u>				23D. ADDRESS <u>1916 BELAIR ROAD FAUSTON MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-2-69</u>		24C. NAME of CEMETERY <u>UNIVERSITY MEDICAL SCHOOL</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-450		69 12119		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12119	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Lulu H Fallon			
2. DATE AND HOUR OF DEATH Dec 5 1969				M. 5 P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2755			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) The Wesley Home				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
90 2211 W Rogers Ave				E. STREET AND NUMBER 2211 W Rogers Ave			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 26 1889	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington D.C.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William McK Hamack			14. MOTHER'S MAIDEN NAME Martha Cecelia Markwood				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220 44 6711		17. INFORMANT ADDRESS The Wesley Home		
18. 412.3 I			CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary insufficiency				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:				
(C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 26 October 19 69 to 5 December 19 69 , that (I) (we) last saw the deceased alive on 2 December 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE John W Barnaby				DEGREE		23B. DATE SIGNED 8 Dec 69	
23C. PHYSICIAN'S NAME (Type) Dr John W Barnaby				23D. ADDRESS 1652 E Belvedere Ave			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 12-8-69		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem		24D. LOCATION (City, town, or county) (State) Pikesville Balto Co Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR Burgee Funeral Home		ADDRESS Baltimore Md	



K-540

69 12120 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12120

BIRTH NO.

1. NAME OF DECEASED (Type or Print) ELSIE KINLEY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 4 69 4:45 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour December 4, 1969 4:45 p.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1203	
9. DATE OF BIRTH March 30, 1934		10. AGE (In years last birthday) 35 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Home	
15. MOTHER'S MAIDEN NAME Hazel L. Stroupe		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 213-30-0708		18. INFORMANT Marvin E. Kinley	
19. 430.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Subarachnoid hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		ADDRESS Concorde, N.C.	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) YES	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. DATE SIGNED 12/5/69 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/69	
24C. NAME of CEMETERY or CREMATORY West Liberty		24D. LOCATION (City, town, or county) (State) Shawsville Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Grant Funeral Home		ADDRESS North East, Md.	

WALTER B. POIR
VALLEY PARK

EXHIBIT 801111

FUNERAL DIRECTOR: IMPORTANT

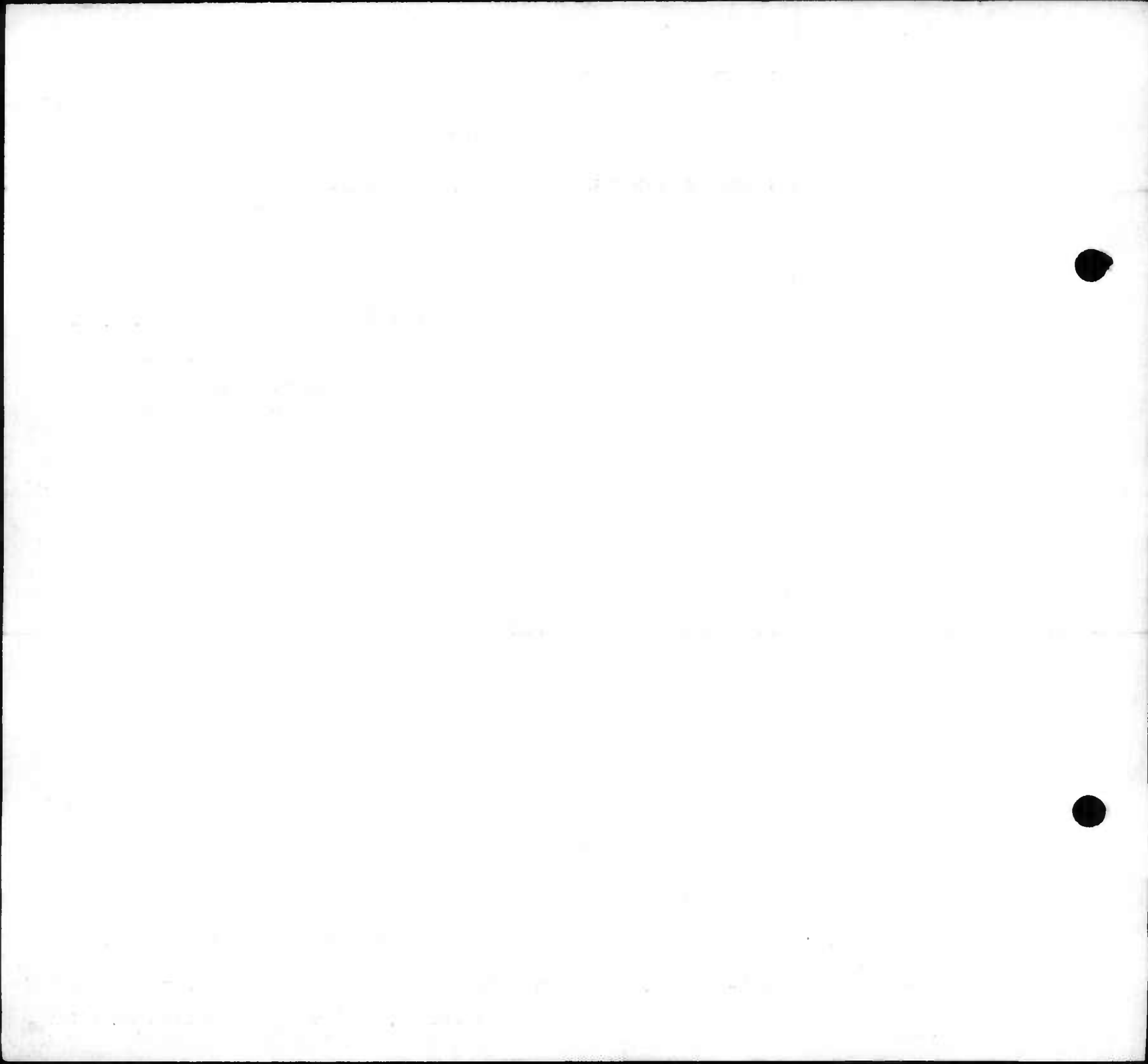
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-356 69 12121		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X WEG. NO. 69 12121	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		BUETTNER MARGEURITE		DECEMBER 6 1969 10:15AM M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST AGNES HOSPITAL CATON & WILKENS AVENUE BALTIMORE MARYLAND 21229		MARYLAND Baltimore 5300			
5. SEX FEMALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
DIETICIAN		HOSPITAL		09/14/00	
13. FATHER'S NAME JOHN CONWAY		14. MOTHER'S MAIDEN NAME MARY J (LINCOLN)		9. AGE (In years last birthday) 69	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
NO		214 03 3425		MARYLAND	
		17. INFORMANT		12. CITIZEN OF WHAT COUNTRY?	
		ST AGNES HOSP CATON & WILKENS AVE		U S A	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CA Left Lung			
		(B) DUE TO, OR AS A CONSEQUENCE OF: Cachexia			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (H) (this hospital) attended the deceased from 12/04/69 19 to 12/06/69 19 that (X) (we) last saw the deceased alive on 12/06/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
MUHAMMAD AFZAL		12-6-69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
M. AFZAL		ST. AGNES HOSPITAL, BALTO., MD. 21229			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		12/9/69		New Cathedral Cemetery	
				Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 9 1969		J. E. Taylor		Ambrose Inc 1328 Sulphur Sp. Rd	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

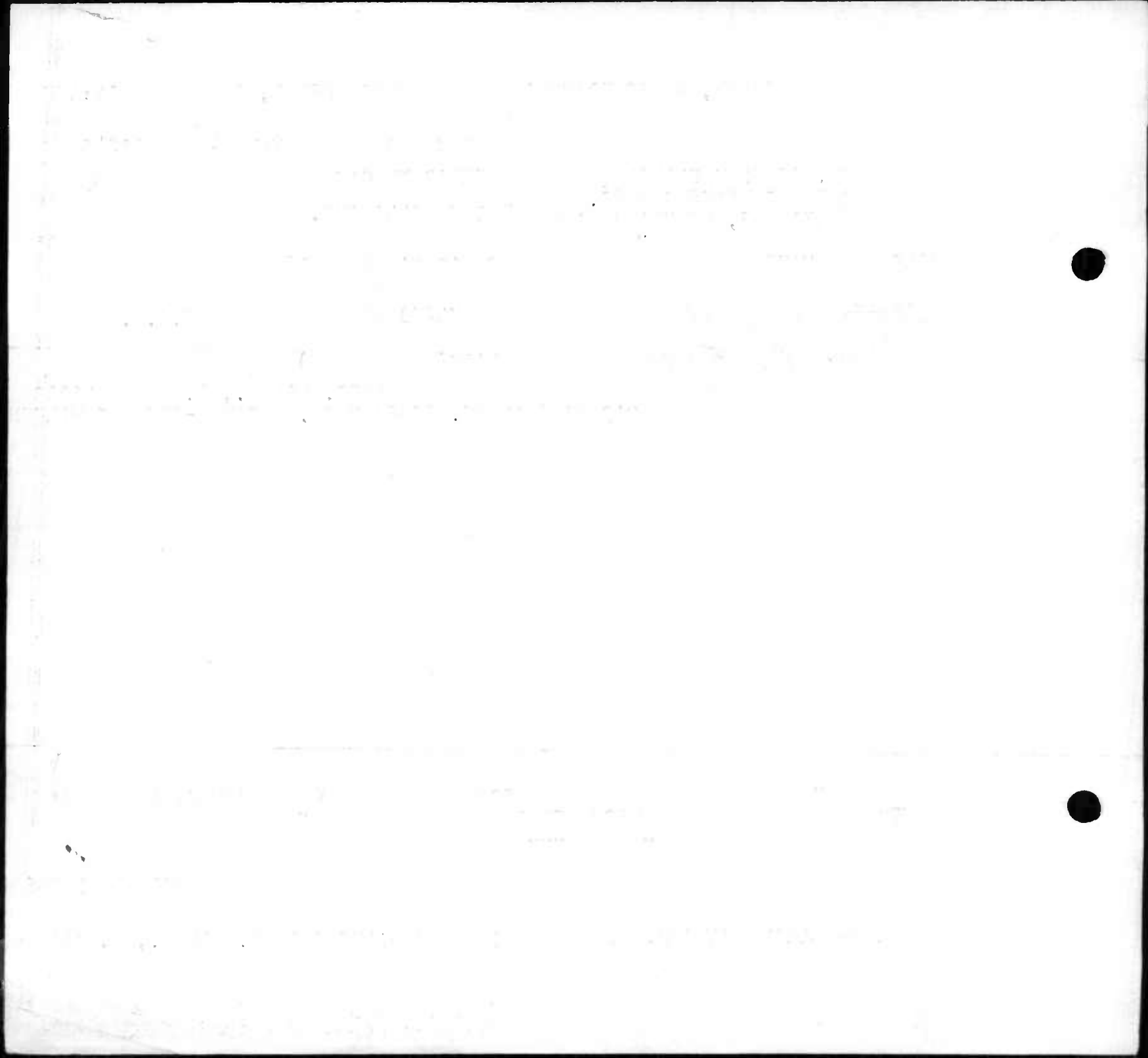
C-400		69 12122		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12122	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) FRANCIS KENNETH COLE <i>Mr. Francis K. Cole</i>				2. DATE AND HOUR OF DEATH 12-8-69 1:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BSH. BON SECOURS HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Ten Oaks Rd 1217			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-1-93	9. AGE (In years last birthday) 76	10. Under 1 Yr. Months: Days: Hours: Min.	11. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retire			10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William Cole			14. MOTHER'S MAIDEN NAME Ziegler, Susanna Ziegler				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 213-18-6450		17. INFORMANT BSh Owings Mills, Maryland ADDRESS 21117 Ruth Dusenbury, Rt. 1 Box 167		
18. 238.11 CAUSE OF DEATH							
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Pulmonary edema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day	
				(B) Brain Tumor DUE TO, OR AS A CONSEQUENCE OF:		1 month	
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-7-1969 to 12-8-1969 that (I) (we) last saw the deceased alive on 12-8-1969 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE N. Rouquatyun MD				23B. DATE SIGNED 12-8-69		23C. PHYSICIAN'S NAME (Type) N. Rouquatyun	
23D. ADDRESS Bon Secours Hospital, Baltimore, Md.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-69		24C. NAME of CEMETERY or CREMATORY St. John's Cemetery		24D. LOCATION (City, town, or county) (State) Howard Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969				25B. FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-460		69 12123		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12123	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
EYLER, JAMES FRANKLIN				DECEMBER 7, 1969 12:45P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229				A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN ELLICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 785 OELLA AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09 19 91	9. AGE (in years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER Textile		10B. KIND OF BUSINESS OR INDUSTRY W.S. Dickey		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William C. EYLER				14. MOTHER'S MAIDEN NAME MARY () DEXTER			
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213 09 6232		17. INFORMANT AVES. BALTO., MD. 21229 ST. AGNES HOSP. RECORDS-CATON & WILKEN			
18. CAUSE OF DEATH 25091 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 2 19 69 to DECEMBER 7 19 69 that (X) (we) last saw the deceased alive on DECEMBER 7 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. Shams, M.D.				23B. DATE SIGNED DECEMBER 7, 1969		23C. PHYSICIAN'S NAME (Type) DR. ABDOLLAH SHAMS M. D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-69		24C. NAME of CEMETERY or CREMATORY St. Johns Cem.		24D. LOCATION (City, town, or county) (State) Ellicott City Howard, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Valley		25C. FUNERAL DIRECTOR Ellicott City			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

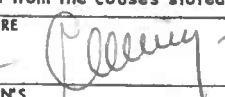
L-145		69 12124		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12124	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) Nettie Mae LA Flame				2. DATE AND HOUR OF DEATH 12-4-1969 3:15 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 21202			
5. SEX female 6. RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 1885 5/3/1884		9. AGE (In years last birthday) 84	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10B. KIND OF BUSINESS OR INDUSTRY Bugle Laundry		11. BIRTHPLACE (State or foreign country) Charlestown, W. Va.	
13. FATHER'S NAME W. H. Anderson				14. MOTHER'S MAIDEN NAME Annie Lucas			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 217-22-8662				16. SOCIAL SECURITY NO. 217-22-8662			
17. INFORMANT Aimee Ringrose, daughter				ADDRESS 4353 Shamrock Ave.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 486X1-230.9 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 1) pneumonia 2) A.S.C.V.H.D ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 3) pulmonary edema 4) Diabetes Mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-15-1969 to 12-4-1969 that (I) (we) last saw the deceased alive on 12-4-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE H. MAKIPOUR				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) HOUSHANG MAKIPOUR				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/69		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 3331 Breems Lane	

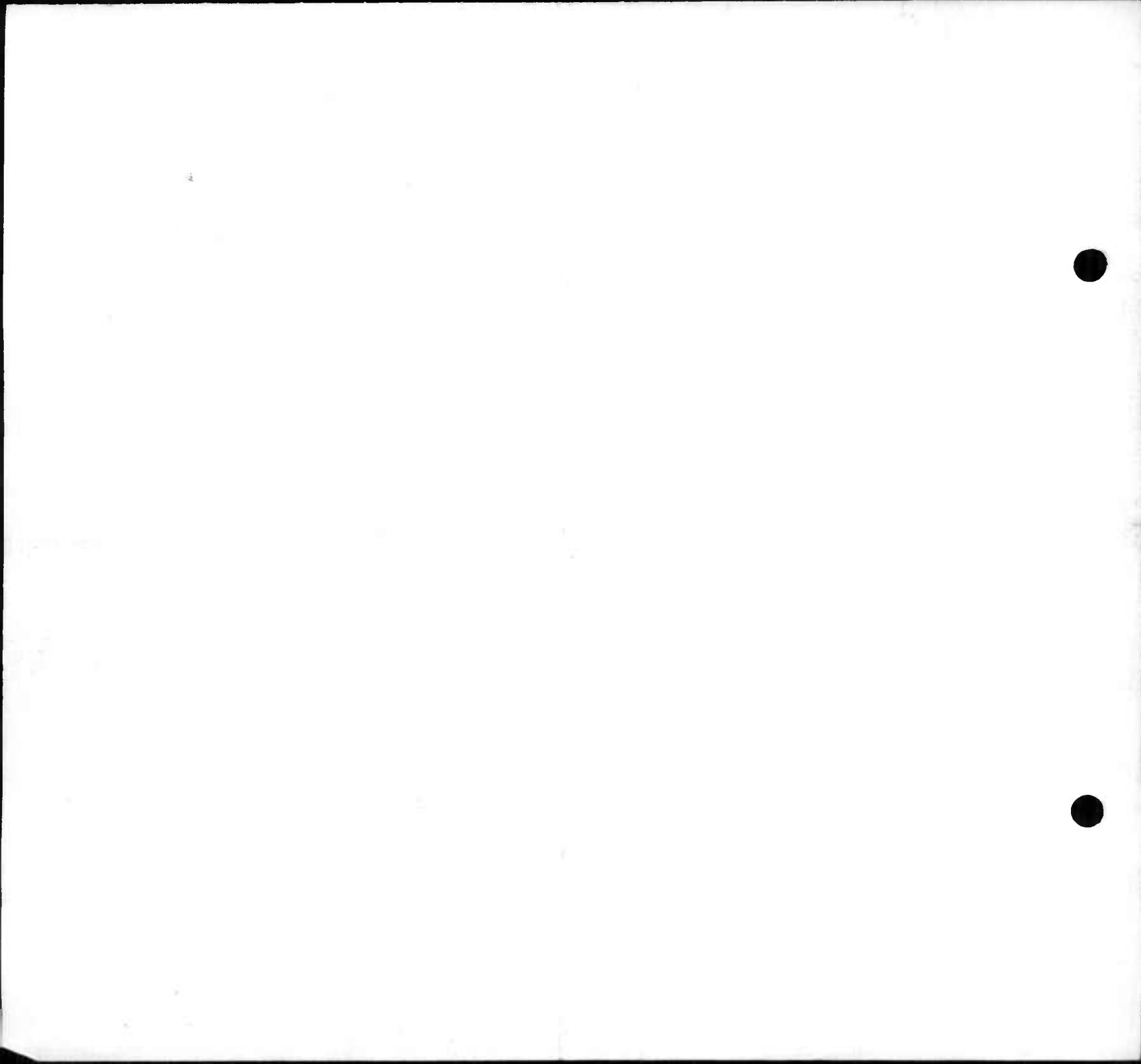
12/12/69 - Correction form from funeral director.

Life.

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12125	
W-425 69 12125		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) JOHN J. WILSON		2. DATE AND HOUR OF DEATH DEC. 4, 1969 8.20 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MOUNT SINAI HOSPITAL OF BALTIMORE 90		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE BALTIMORE, MARYLAND B. COUNTY 2758	
5. SEX MALE 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-20-1892 9. AGE (in years last birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Warehouseman		10B. KIND OF BUSINESS OR INDUSTRY Merchants Terminal	
11. BIRTHPLACE (State or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) (If yes, give war or dates of service) 212-03-7635A		16. SOCIAL SECURITY NO. 212-03-7635A	
17. INFORMANT Naomi Wilson, wife, above		ADDRESS DAUGHTER.	
18. 492X CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4.5 min (A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) BRONCHIAL SPASM, CHRONIC EMPHYSEMA DUE TO, OR AS A CONSEQUENCE OF: 2 YEARS. (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC 3 19 69 to DEC 4 19 69 that (I) (we) last saw the deceased alive on DEC 4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE 		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) ROGELIO ESCARREGA, M.D.		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/69	
24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Schimmek Funeral Home, Inc.		ADDRESS 93331 Brehms Lane	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>69 12126</u>	
K-613 69 12126			
BIRTH NO. <u>1</u>			
1. NAME OF DECEASED (Type or Print) KRAFT EDWARD FRANK		2. DATE AND HOUR OF DEATH December 5, 1969 11.55 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 831	
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2872 MAYFIELD AVENUE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-18-99
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oiler		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel	9. AGE (In years last birthday) 70
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service 219-03-3248		16. SOCIAL SECURITY NO. 219-03-3248	
17. INFORMANT Carmelita Tuohy Kraft, wife, above		ADDRESS	
18. 431.0 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebrovascular Accident ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. INTRACEREBRAL Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arterial Hypertension			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December 5, 1969 to December 5, 1969 that (I) (we) last saw the deceased alive on December 5, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Miguel Karacuschansky M.D.		23B. DATE SIGNED December 6, 1969	
23C. PHYSICIAN'S NAME (Type) Miguel KARACUSCHANSKY M.D.		23D. ADDRESS Union Memorial Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/69	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Sehinunek Funeral Home, Inc.		ADDRESS 3331 Brehms Lane	

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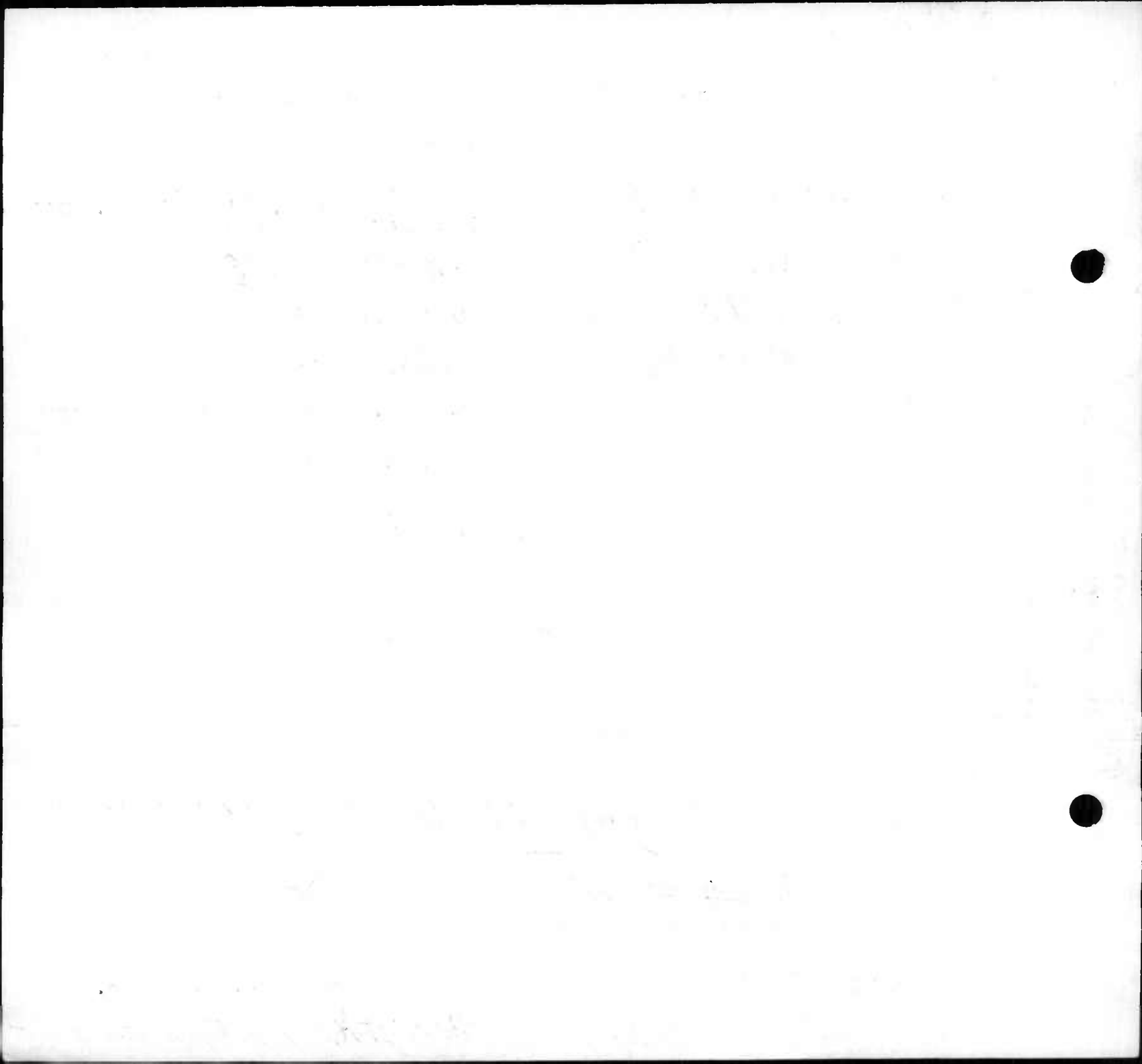
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FUNERAL DIRECTOR: IMPORTANT

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M-240		69 12127		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12127	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) JOSEPH Lyn Mc CAULEY				2. DATE AND HOUR OF DEATH Dec 6 - 1969 7:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Balt Gen Hosp 43				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2534			
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-18-11	
9. AGE (In years last birthday) 58		10. UNDER 1 Yr. Months: Days: Hours: Min.		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker				10B. KIND OF BUSINESS OR INDUSTRY Carpenter			
13. FATHER'S NAME Lee McCauley				14. MOTHER'S MAIDEN NAME Susie Hicks			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Mae A. McCauley			
18. 105.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Metastasis Carcinoma		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 1° in liver ??		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. myocardial Infarct.							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Involuntarily medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from 11/23/65 7:40 a to 7:00 p 12-6-1969 . that (we) last saw the deceased alive on 7:10 p 12-6-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.							
23A. SIGNATURE Henry C. C. [Signature]				23B. DATE SIGNED 12-6-69		23C. PHYSICIAN'S NAME (Type) HENRY C. C. [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/69		24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md. A A Co.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]		ADDRESS 237 Patuxent Ave 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

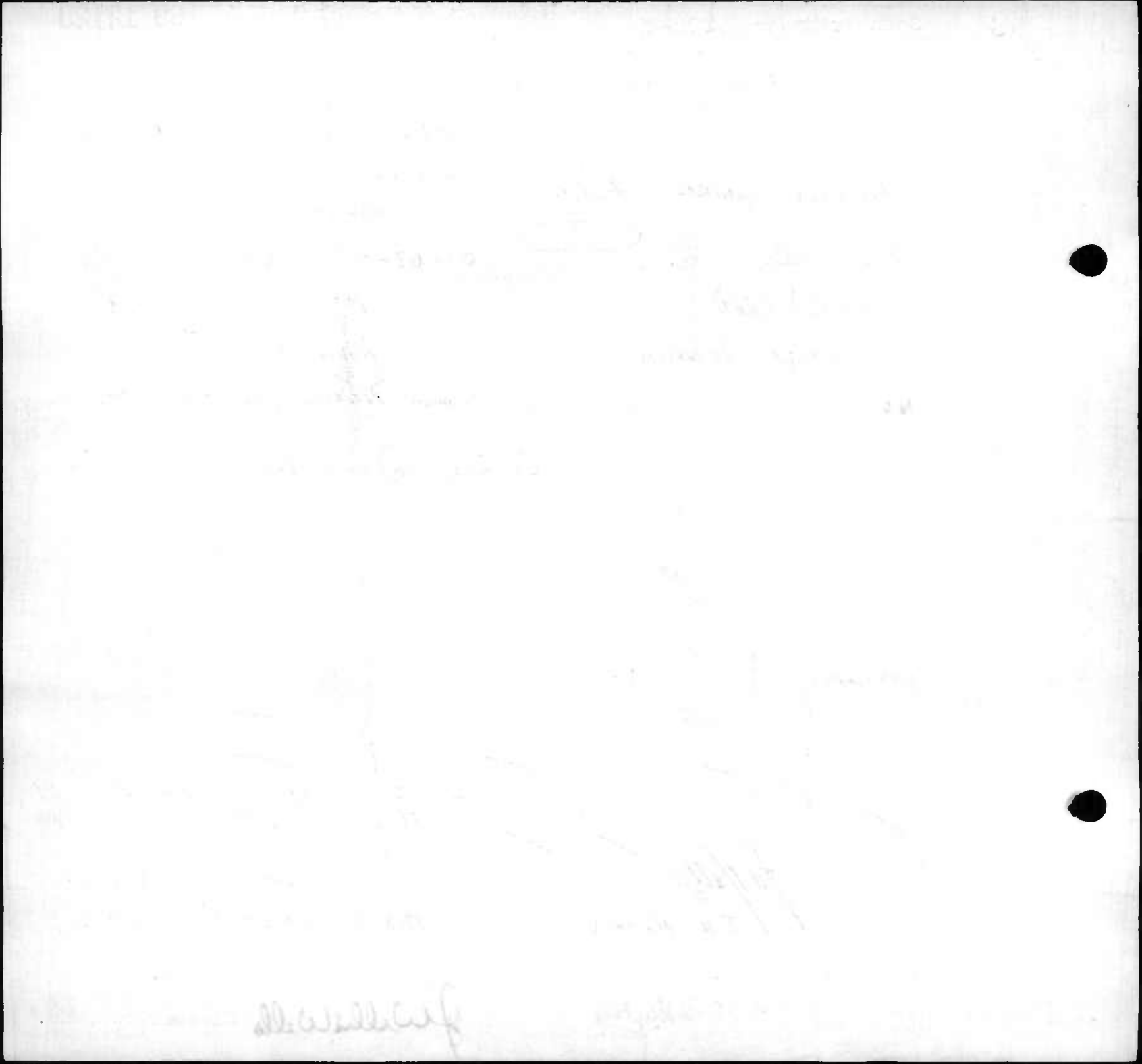
B-000 69 12128		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12128	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ETTA LEW BEW		2. DATE AND HOUR OF DEATH 12-6-69 10:55P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2574			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 931 Maydon Court 21225			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-14-98	9. AGE (in years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA	
13. FATHER'S NAME PROSE PRINCE		14. MOTHER'S MAIDEN NAME MARY Unknown		12. CITIZEN OF WHAT COUNTRY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Otis F. Bew 931 Maydon Court 21225	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute myocardial Infarct ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Arteriosclerotic cardiovascular heart disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9:45 PM 12-2-19 69 to 10:55 PM 12-6-19 69 , that (I) (we) last saw the deceased alive on 10:55 PM 12-6-19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Virginia Y. Fausto, M.D.		23B. DATE SIGNED 12-6-69		23C. PHYSICIAN'S NAME (Type) VIRGINIA Y. FAUSTO, M.D.	
23D. ADDRESS 3001 S. Hanover Street					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Ritchie Highway A. A. Co. Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR McCallie FH 237 Patuxent Ave 21225	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

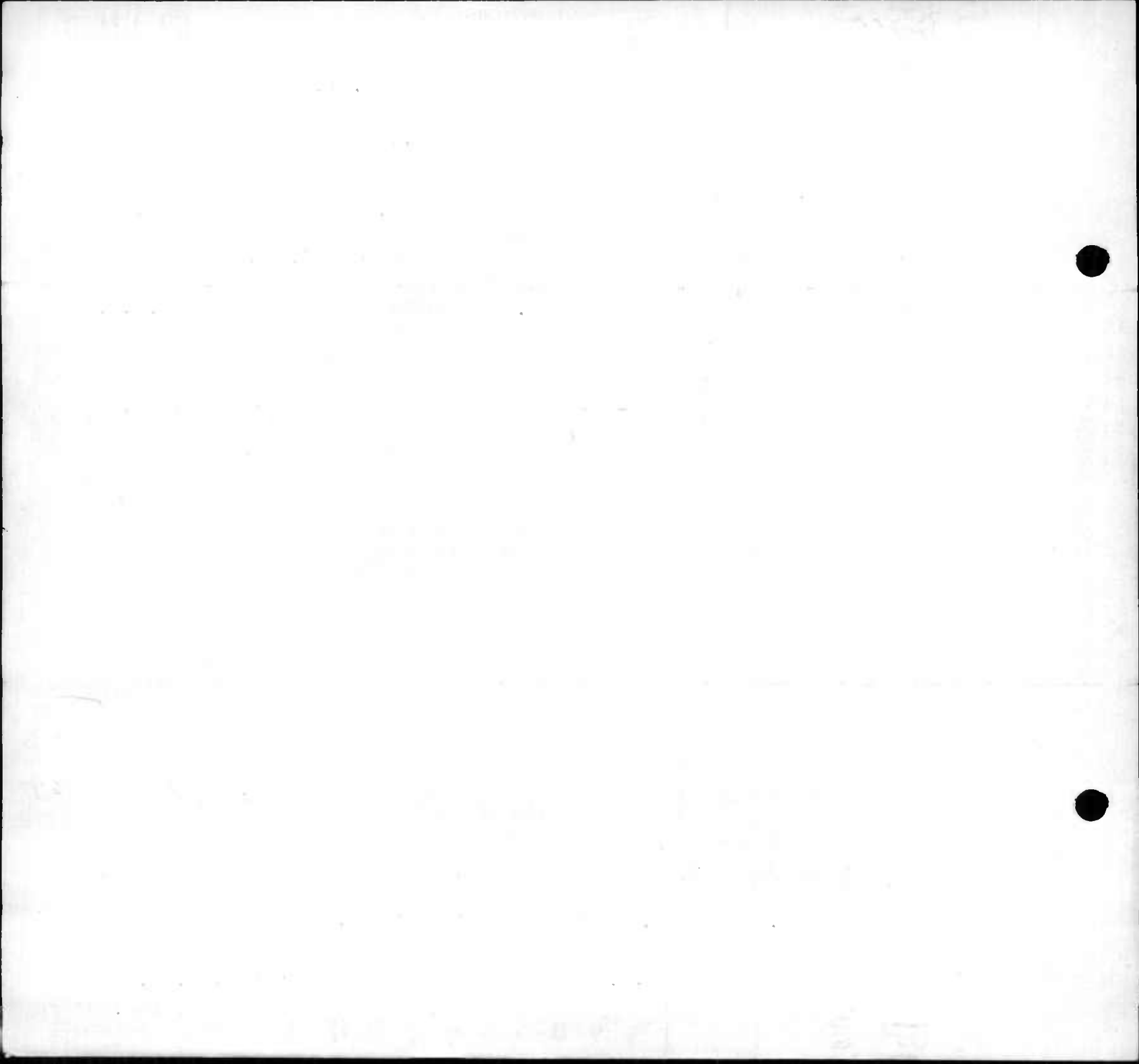
Baltimore City Health Department				69 12129	
Spencer Moody PETERSON				Registered No.	
69 12129				1-20-P M.	
1. NAME OF DECEASED (Type or Print) SPENCER MOODY PETERSON				2. DATE AND HOUR OF DEATH 12-6-69	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION 48 MARYLAND GENERAL HOSPITAL				A. STATE MD. B. COUNTY Kent C. CITY OR TOWN CHESTER TOWN	
(If not in hospital or institution, give street address or location)				D. STREET ADDRESS (If rural, give location) HIGH ST.	
5. SEX Male	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)		8. DATE OF BIRTH 01-03-00	9. AGE (In years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER (RED)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTHONY PETERSON				14. MOTHER'S MAIDEN NAME ANNIE BIDDLE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213 03 0014	
17. INFORMANT Norman PETERSON (BROTHER)				ADDRESS 778-4409	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I CA. LUNG. (L) MAIN BRONCHUS. INTERVAL BETWEEN ONSET AND DEATH ABOVE 6 MTHS.					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION BRONCHOSCOPY		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA.		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-2 19 69 to 12-6 19 69 , that (I) (we) last saw the deceased alive on 12-6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J.H. MATHER				23B. DATE SIGNED 12-6-69	
23C. PHYSICIAN'S NAME (Type) J.H. MATHER				23D. ADDRESS 5308-D LEITH RD. 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/1969		24C. NAME of CEMETERY or CREMATORY Chester Cemetery	
				24D. LOCATION (City, town, or county) (State) Chestertown, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR John E. Fisher		25C. FUNERAL DIRECTOR J. Willis Wells	
				ADDRESS Chestertown, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12130
D-120		69 12130		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIAM DAVIS		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH Dec. 4, 1969 M.		
FULL NAME OF HOSPITAL OR INSTITUTION 00 34 S. East Avenue		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md., 21224 B. COUNTY 2610		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 34 S. East Avenue		
5. SEX male	6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/1903	9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Work		10B. KIND OF BUSINESS OR INDUSTRY Eastern Box Co.		11. BIRTHPLACE (State or foreign country) Russia
13. FATHER'S NAME unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 212-34-5270A		17. INFORMANT Estelle Rochowicz Davis, wife, above
18. 492X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Cardiac arrest ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Emphysema		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1963 19 to Dec 4 19 69 , that (I) (we) last saw the deceased alive on 9:15 Dec 4 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <i>Charles C. MacMinn</i>				23B. DATE SIGNED Dec 5, 1969
23C. PHYSICIAN'S NAME (Type) Dr. Charles C. MacMinn		23D. ADDRESS 2900 E. Baltimore Street		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/7/69		24C. NAME OF CEMETERY or CREMATORY D.C. Lodge Cemetery
24D. LOCATION (City, town, or county) (State) Washington, D. C.				
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Charles C. MacMinn		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Biehms Lane



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>R-320 69 12131 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.5em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12131</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) RUTHKE, ROSE</p>		<p>2. DATE AND HOUR OF DEATH December 6, 1969 2.10 A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>44 UNION MEMORIAL Hospital</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY BALTIMORE</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 6715 COLLINSDALE ROAD</p>	
<p>5. SEX FEMALE</p>	<p>6. RACE WHITE</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 04-15-88</p>
<p>9. AGE (In years last birthday) 81</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE</p>	<p>11. BIRTHPLACE (State or foreign country) AUSTRALIA</p>
<p>12. CITIZEN OF WHAT COUNTRY? U.S.A</p>		<p>13. FATHER'S NAME UNKNOWN Nick</p>	
<p>14. MOTHER'S MAIDEN NAME UNKNOWN</p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>	
<p>16. SOCIAL SECURITY NO. 271-31-3005B</p>		<p>17. INFORMANT Mr John Ruthke ADDRESS Same</p>	
<p>18. 1621 I CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE CARCINOMA OF THE LUNG DUE TO, OR AS A CONSEQUENCE OF: 2 years</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: _____</p> <p>(C) DUE TO, OR AS A CONSEQUENCE OF: _____</p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NO</p>	
<p>20A. AUTOPSY? (Yes or No) NO</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>		<p>21D. TIME OF INJURY (APPROX) (Month) (Day) (Year) (Hour) _____</p>	
<p>21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from November 25 1969 to December 6 1969 that (I) (we) last saw the deceased alive on December 6 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Miguel Karacuschansky M.D.</p>		<p>23B. DATE SIGNED December 6, 1969</p>	
<p>23C. PHYSICIAN'S NAME (Type) MIGUEL KARACUSCHANSKY M.D.</p>		<p>23D. ADDRESS UNION MEMORIAL HOSPITAL</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 12/9/69</p>	
<p>24C. NAME of CEMETERY or CREMATORY Druid Ridge</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor</p>	
<p>25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.</p>		<p>ADDRESS Baltimore, Maryland</p>	

594 W. S. G. et al.

TABLE 1

1990年12月14日

FUNERAL DIRECTOR: IMPORTANT

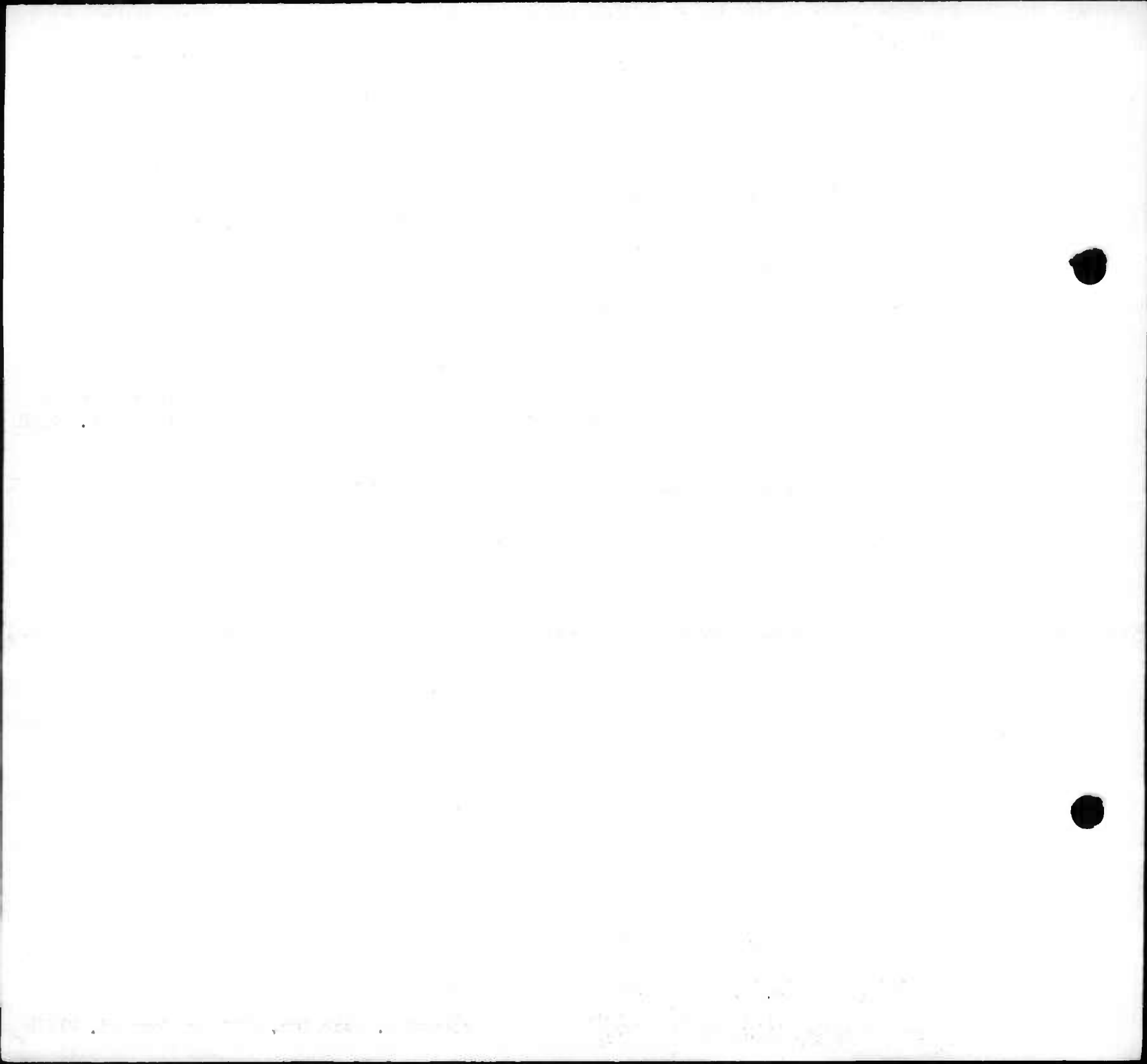
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-610		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12132	
BIRTH NO.		69 12132		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>MRS. ELEANOR KIRBY</u>		2. DATE AND HOUR OF DEATH <u>12/6/69 5:40 pm</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME & HOSPITAL</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>5100 N. BROADWAY, BALTO. MD.</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>5100 N. BROADWAY, BALTO. MD.</u>		F. STREET AND NUMBER <u>423 Dumbarton Rd</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4.20.93</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>WILLIAM RAUCH</u>		14. MOTHER'S MAIDEN NAME <u>THERESA KOENIG</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 42 1339</u>		17. INFORMANT <u>MRS. ELMER CASSIDY</u> ADDRESS <u>423 DUMBARTON RD.</u>	
18. <u>410.0 + 250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarct</u> (B) <u>HASCVT</u> (C) <u>Severe Bronchial Asthma</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>Many yrs</u> <u>" "</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Diabetes & Urinary Tract Infection</u>		19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>many years</u> 19 <u>12/5</u> to <u>12/6</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12/5</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Samuel Morrison MD</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>SAMUEL MORRISON MD</u>		23D. ADDRESS <u>11 E. Chase St. Balto Md 21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/10/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u> ADDRESS <u>Baltimore, Maryland</u>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12133</u>	
M-460				69 12133	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>JOHN M. Miller</u>			2. DATE AND HOUR OF DEATH <u>December 7, 1969 7:10 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4 Bon Secours Hospital</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2634</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5338 WRIGHT Avenue</u>		
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>8-25-80</u>	9. AGE (In years last birthday) <u>89</u>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>UNITED STATES</u>
13. FATHER'S NAME <u>JOHN M. MILLER</u>			14. MOTHER'S MAIDEN NAME <u>FRANKIS MILLER UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>212-07-5866</u>	17. INFORMANT <u>MRS. H.B. YOUNG</u> ADDRESS <u>405 Raymond Avenue Alexandria Va. 22301</u>		
18. <u>412.41</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Congestive heart failure, 2 months</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-11</u> 19 <u>69</u> to <u>12-7</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12-7</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Inkun Shin M.D.</u>			23B. DATE SIGNED <u>12-7-69</u>		23C. PHYSICIAN'S NAME (Type) <u>INKUN SHIN M.D.</u>
23D. ADDRESS <u>BON SECOURS HOSPITAL BALTIMORE, Md 21203</u>			24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		
24B. DATE <u>12/10/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Jessup Methodist Church</u>		24D. LOCATION (City, town, or county) (State) <u>Sparks Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. 5305 Harford Rd. 21214</u>	



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C-640 69 12134 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
BIRTH NO. 65-25105 REG. NO. 69 12134

1. NAME OF DECEASED (Type or Print) Karen Denise CORWELL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> December 6, 1969 10:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 6, 1969 10:00 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2702		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH Oct 8, 1965	10. AGE (In years last birthday) 4	11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Harry C Corwell	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		15. MOTHER'S MAIDEN NAME Jeane D Webster	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. None	
18. INFORMANT Mr Harry C Corwell		ADDRESS 941 Southridge Rd	
19. E812.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebro-cranial injuries DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 12/10/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street	
22D. TIME OF INJURY (APPROX.) December 6, '69 12:15 P.M.		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Howard & Centre Streets - Intersection	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Passenger in auto-auto collision	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 7, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69	
24C. NAME OF CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Leonard J Ruck Inc.		ADDRESS Baltimore, Maryland	

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R-360

69 12135 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12135

BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELLA M REUTER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month December Day 6 Year 1969 Estimated <input type="checkbox"/>		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2031 Hillenwood Rd. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month December Day 6 Year 1969		Hour 10:01 A.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2749	
6. SEX Female	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH March 5, 1887		10. AGE (In years last birthday) 82 If Under 1 Yr. if Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER 2031 Hillenwood Rd.			
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.		13. FATHER'S NAME Sommers			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Florence Morningstar			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 212-10-1685		18. INFORMANT Mrs Audrey Willis		ADDRESS Same	
19. 4124 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-6-69							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/69		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Leonard J Ruck Inc. Baltimore, Maryland			

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69 12136 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12136

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) JOSEPH Raymond BETHEL		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 5, 1969		M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) House in the Pines 5837 Belair Rd.		3. DATE PRONOUNCED DEAD Month Day Year Hour December 5, 1969 7:10 P.M.		
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH 9/6/1897		10. AGE (In years last birthday) 72		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Horace A. Bethel		14. USUAL OCCUPATION (Give kind of work done during life, even if retired) Bookkeeper
15. MOTHER'S MAIDEN NAME Louise A. ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 214-01-5149
18. INFORMANT Mr. Harry Sloan Jr.		ADDRESS 2908 Halcyon Avenue		
19. CAUSE OF DEATH E814.1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., it means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Arteriosclerotic cardiovascular disease		(A) IMMEDIATE CAUSE Pulmonary thromboemboli DUE TO, OR AS A CONSEQUENCE OF: (B) Blunt injuries DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Harford Rd. at Halcyon Ave. 2793
22D. TIME (Month) (Day) (Year) (Hour) (APPROX.) 9-29-69 8:15 P		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Pedestrian struck by car
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-6-69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/69		24C. NAME of CEMETERY or CREMATORY Meadowridge Cemetery
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd. 21214		

1. TITLE: [Illegible]

2. AUTHOR: [Illegible]

3. DATE: [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

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16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

28. [Illegible]

29. [Illegible]

30. [Illegible]

31. [Illegible]

32. [Illegible]

33. [Illegible]

34. [Illegible]

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W-430

69 12137

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12137

BIRTH NO.		1. NAME OF DECEASED (Type or Print) M LEONARD WALD		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 5 69 10:18a.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital D.O.A.		3. DATE PRONOUNCED DEAD Month Day Year Hour December 5, 1969 10:18a m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 901	
6. SEX Male	7. RACE White	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 7, 1917		10. AGE (In years lost birthday) 52	11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Field Representative Social Security Adm.		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Jennie ?	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 11		17. SOCIAL SECURITY NO. 468-07-3415		18. INFORMANT ADDRESS Mrs Frances Wald Same	
19. 412.4 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
(B) DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/5/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69		24C. NAME OF CEMETERY or CREMATORY Knollwood	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J Ruck Inc, Baltimore, Maryland	

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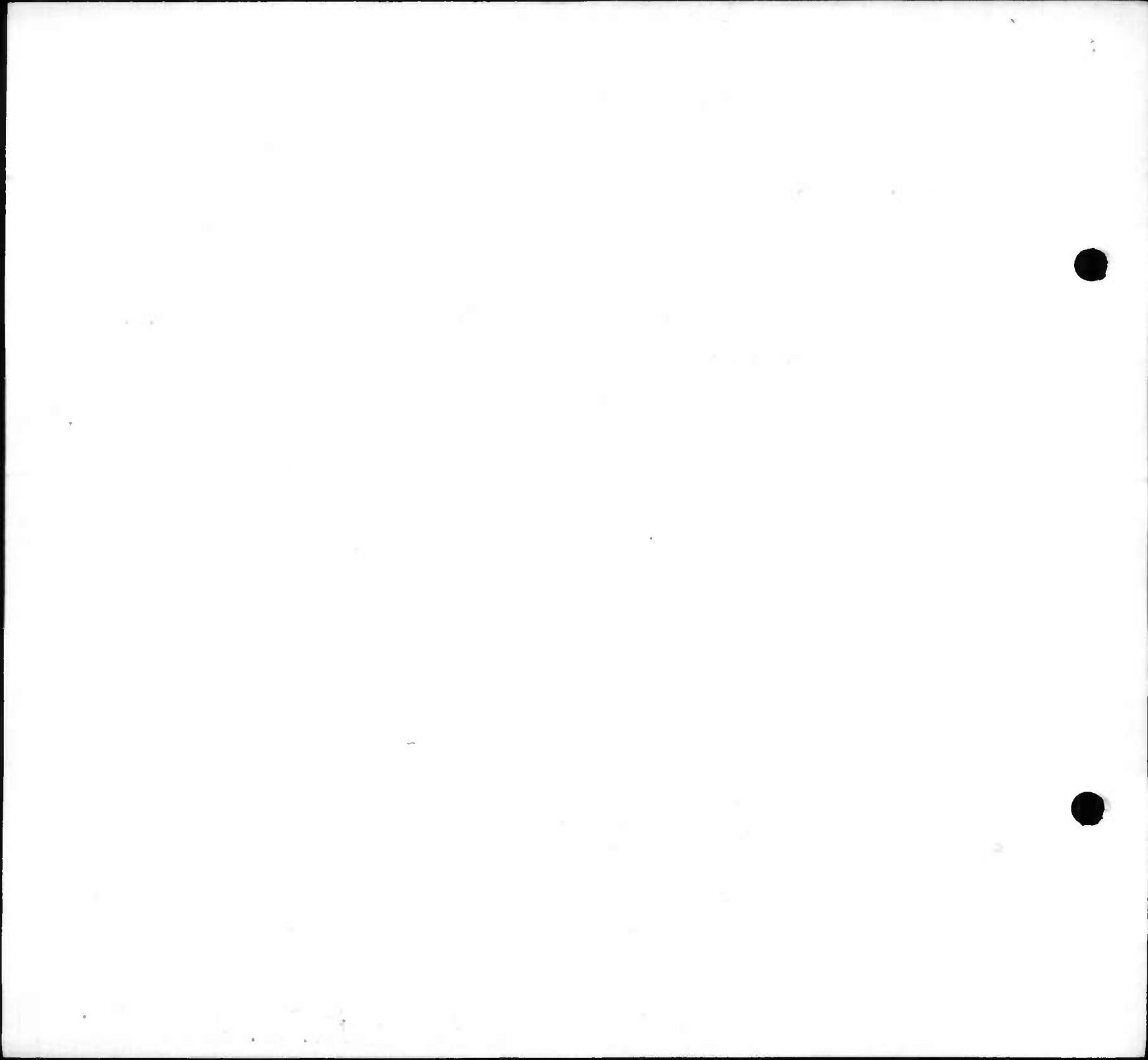
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-532		69 12138		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12138	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>MONDSHOOR, BENJAMIN C.</i>			
2. DATE AND HOUR OF DEATH <i>12-7-69 2:25 AM.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>D. O. A. St. Agnes Hospital</i>			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTIMORE</i>		5. CITY OR TOWN		6. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		7. STREET AND NUMBER <i>1826 WINANS AVENUE 21227</i>	
8. SEX <i>M</i>	9. RACE <i>W</i>	10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH <i>2-23-09</i>	12. AGE (In years last birthday) <i>60</i>	13. If Under 1 Yr. Months: Days: Hours: Min.		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipe fitter</i>		15. KIND OF BUSINESS OR INDUSTRY <i>RIGGS DISTER</i>		16. BIRTHPLACE (State or foreign country) <i>Maryland</i>		17. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
18. FATHER'S NAME <i>Cleveland T. Mondshour</i>				19. MOTHER'S MAIDEN NAME <i>Geneveive uzell</i>			
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		21. SOCIAL SECURITY NO. <i>212-01-6609</i>		22. INFORMANT ADDRESS <i>Mrs. Grace Mondshour-1826 Winans Ave.</i>			
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>230.91</i>		24. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic C.V. D</i> (B) DUE TO, OR AS A CONSEQUENCE OF: <i>Diabetes Mellitus</i> (C) _____		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 years</i> <i>12 years</i>			
26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>II</i>							
27. DATE OF OPERATION <i>12-8-69</i>		28. CONDITION FOR WHICH OPERATION WAS PERFORMED		29. AUTOPSY? (Yes or No)		30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		32. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		33. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
34. TIME OF INJURY (APPROX.)		35. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		36. HOW DID INJURY OCCUR?			
37. I certify that (I) (this hospital) attended the deceased from <i>November 19 64</i> to <i>Nov. 12 19 69</i> that (I) (we) lost saw the deceased alive on <i>Nov 12th</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
38. SIGNATURE <i>Harry F. Kates MD</i>				39. DATE SIGNED <i>12-8-69</i>		40. ADDRESS <i>517 SCOTT ST. BALT. MD.</i>	
41. PHYSICIAN'S NAME (Type) <i>HARRY F. KATES MD</i>		42. NAME of CEMETERY or CREMATORY <i>Western Cemetery</i>		43. LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>		44. DATE REC'D BY HEALTH DEPT. <i>DEC 9 1969</i>	
45. NAME OF REGISTRAR <i>Robert E. Farley MD</i>		46. FUNERAL DIRECTOR <i>Witzke Inc.</i>		47. ADDRESS <i>1630 Edmondson Ave. Balto. Md. 21228</i>		48. DATE <i>DEC 9 1969</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-235		69 12139		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 69 12139	
1. NAME OF DECEASED (Type or Print) Hastings, Edward W.				2. DATE AND HOUR OF DEATH 12-7-69 8:05 PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Agnes Hospital Caton & Wilkens Avenue Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5506 Calvert Road F. CITY OR TOWN Baltimore G. STATE Maryland H. ZIP CODE 21207					
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/6/08		9. AGE (In years last birthday) 61		10. If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician				10B. KIND OF BUSINESS OR INDUSTRY Hecht's Child Household Kohn		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Hastings				14. MOTHER'S MAIDEN NAME Mable					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 213-03-6185		17. INFORMANT Mrs. Marie Hastings-5508 Calvert Road			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Pump failure DUE TO, OR AS A CONSEQUENCE OF: (B) Post-tumor wall infarct. DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from DECEMBER 7 19 69 to DECEMBER 7 19 69 and that (I) (we) last saw the deceased alive on DECEMBER 7 19 69 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Gloria G. Boonswang M.D.				23B. DATE SIGNED 7 December 69					
23C. PHYSICIAN'S NAME (Type) GLORIA G. BOONSWANG M.D.				23D. ADDRESS St. Agnes Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69		24C. NAME of CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969				25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR Gutzke Inc. 1630 Edmondson Ave. Baltimore, Md 21228			

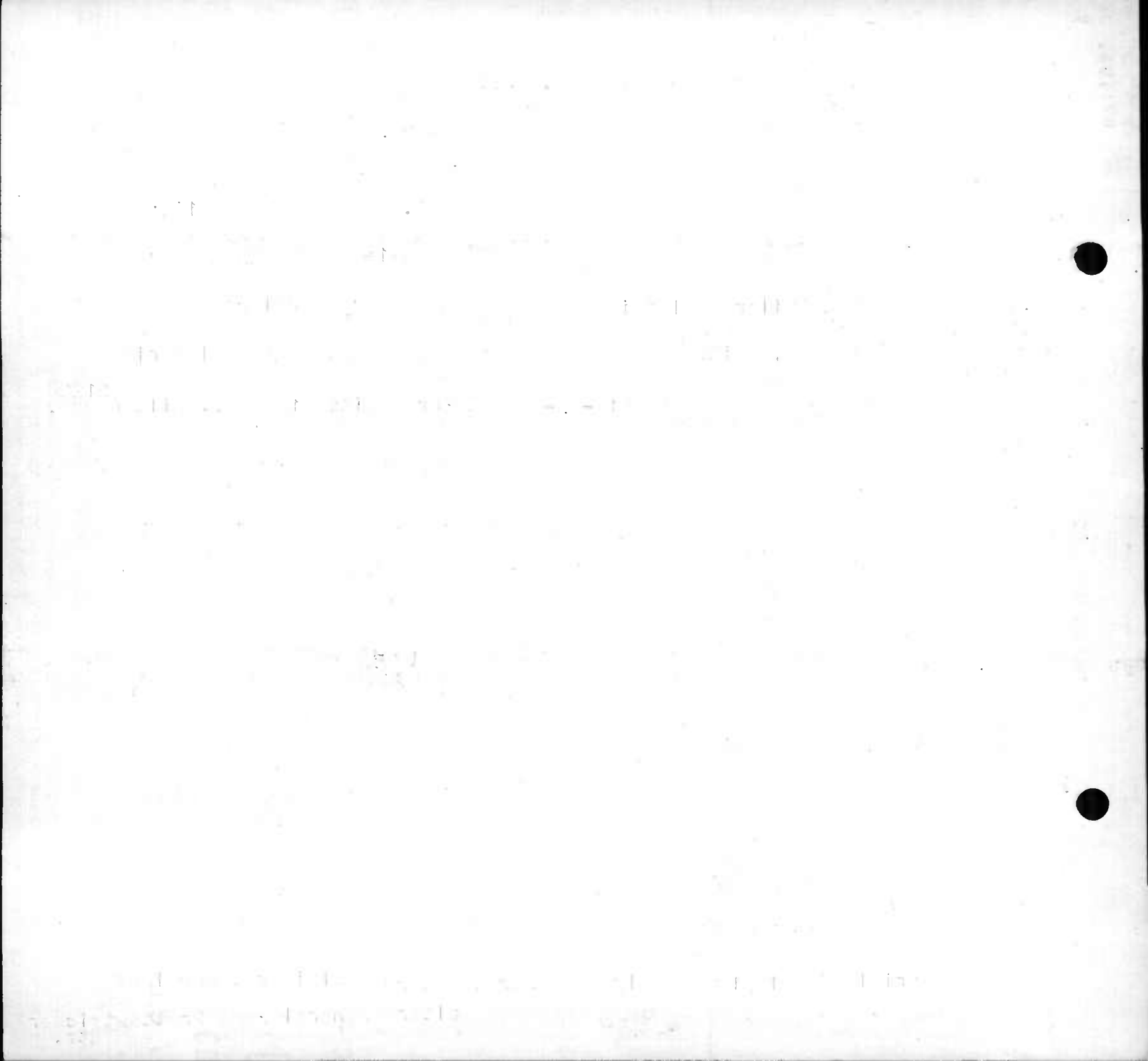
12/18/69 - Correction form from funeral director.

ABe

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

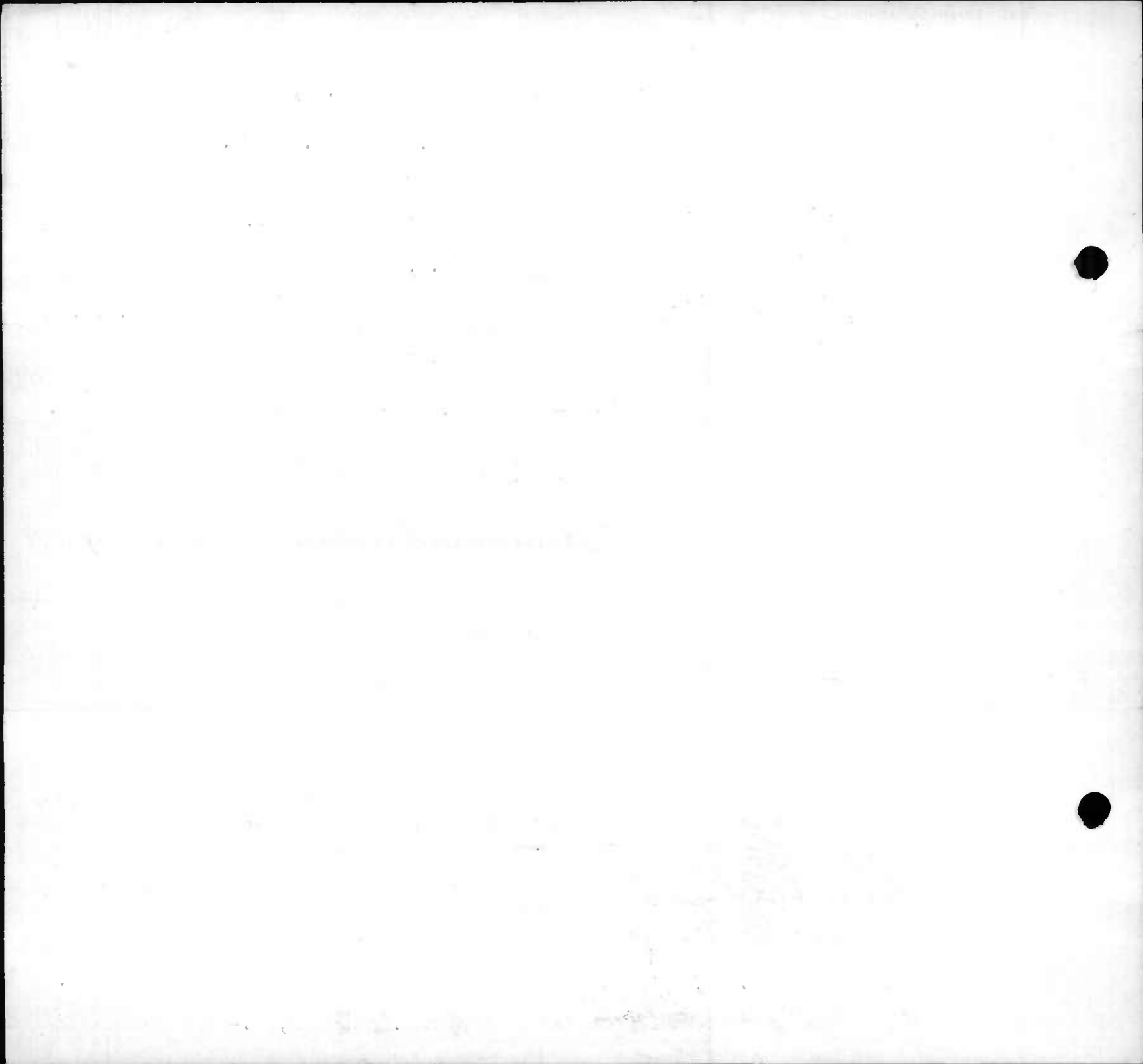
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12140
U-532 BIRTH NO.		69 12140 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) JOHN UNITAS JOHN A. UNITAS		2. DATE AND HOUR OF DEATH 12pm 12/6/69 110 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL 33		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 702 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER BLUMONT FORD AVE 21205		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/1/22-14	9. AGE (In years, last birthday) 55
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXX Tailor		10B. KIND OF BUSINESS OR INDUSTRY Clothing		11. BIRTHPLACE (State or foreign country) BALTIMORE Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN A. Unitas		
14. MOTHER'S MAIDEN NAME XXXXXXX Agatha Slogaris		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO. 214-03-0068		17. INFORMANT ADDRESS Edward Unitas 1008 So. Hilton Ave. 21228		
18. 269.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE ?PULMONARY EMBOLISM DUE TO, OR AS A CONSEQUENCE OF: (B) EDMA 20 HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF: (C) MALABSORPTIVE SYNDROME APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH terminal years year		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 2		20A. AUTOPSY (Yes or No) YES NONE
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? (If in Baltimore City, give exact location)		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11/5 19 69 to 12/6 19 69 , that (I) (we) last saw the deceased alive on 12/6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Thomas E. Inui		23B. DATE SIGNED 12/6/69		23C. PHYSICIAN'S NAME (Type) THOMAS INUI
23D. ADDRESS JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 12/10/69		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Inui		25C. FUNERAL DIRECTOR ADDRESS Walters Funeral Home Pratt & Stricker Sts.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12141	
BIRTH NO. H-620		69 12141		CERTIFICATE OF DEATH X	
1. NAME OF DECEASED (Type or Print) GARDNER HARRIS			2. DATE AND HOUR OF DEATH Dec. 7, 1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 90 Pleasant Manor Nursing Home			A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN Rockdale D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Nov. 1, 1887 9. AGE (In years last birthday) 82		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired, salesman			11. BIRTHPLACE (State or foreign country) Maryland		
10B. KIND OF BUSINESS OR INDUSTRY Miller Richardson			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Eugene Harris			14. MOTHER'S MAIDEN NAME Clair ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W W 1			16. SOCIAL SECURITY NO. 215-10-7533		
17. INFORMANT Mrs. Hazel Harris-3725 Washington Ave.			ADDRESS		
18. 412.41			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE Cardiac arrest		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: Antihypertensive cardiovascular disease		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			(C) Urinary		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-20 1969 to 12-7 1969 , that (I) (we) last saw the deceased alive on 12-5 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Frank G. Kuehn				23B. DATE SIGNED 12-7-69	
23C. PHYSICIAN'S NAME (Type) FRANK G. KUEHN				23D. ADDRESS 721 med arts Bldg. Balto 1 Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 10, 69		24C. NAME OF CEMETERY or CREMATORY Lorraine	
24D. LOCATION (City, town, or county) (State) Woodlawn Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969			
25B. NAME OF REGISTRAR John T. Starbury, Sr.		25C. FUNERAL DIRECTOR ADDRESS 6411 Windsor Mill Rd			

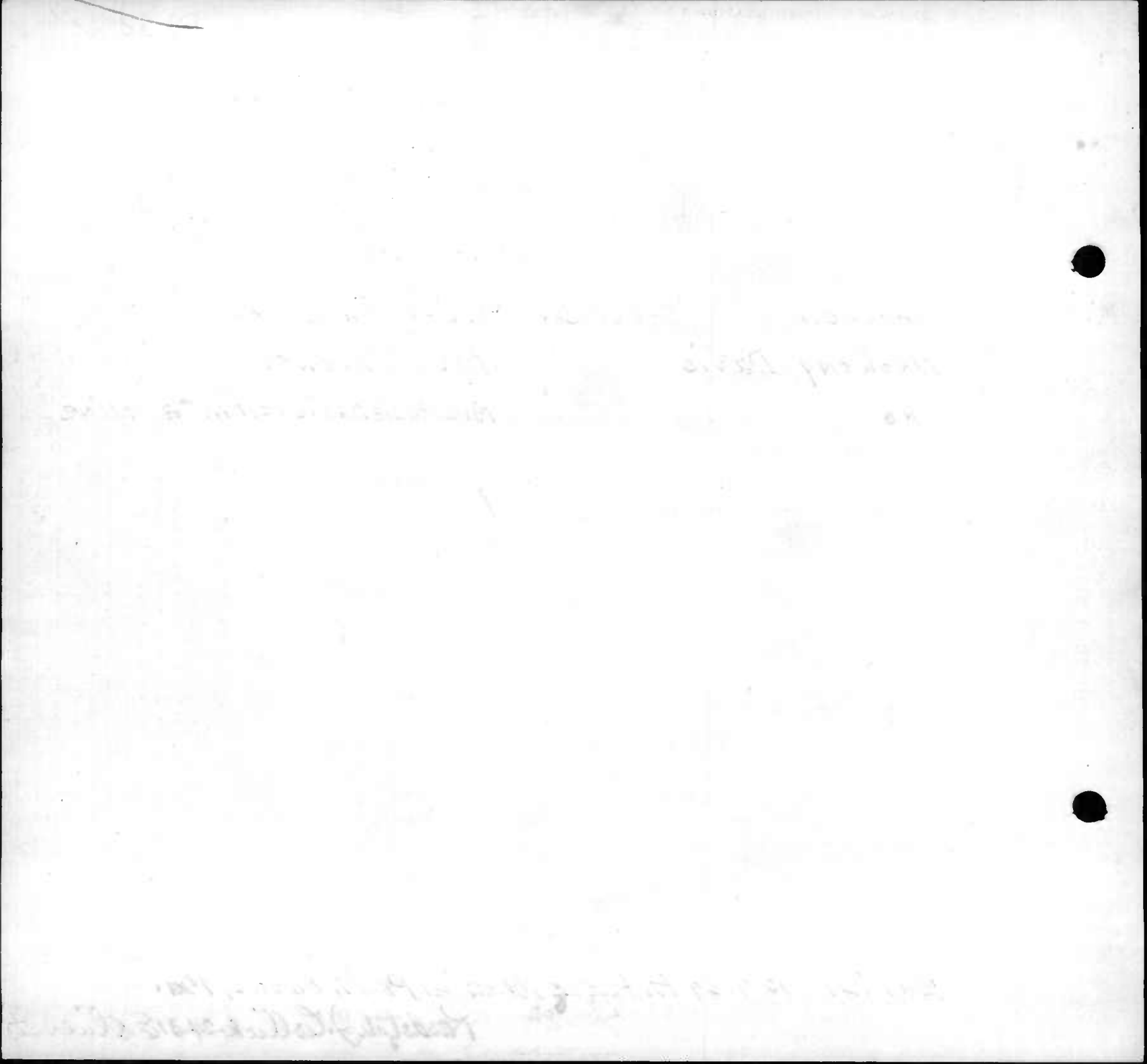


D-1201

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12142	
BIRTH NO. 69 12142		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Emmett B. Davis</u>		2. DATE AND HOUR OF DEATH <u>12-5-69</u> <u>2:08 P.M.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>909</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1310 N. Caroline Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-21-86</u>	9. AGE (In years last birthday) <u>83</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>White Plains, Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Anthony Davis</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Throver</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Addie Davis 1310 N. Caroline</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardiorespiratory Failure</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>About one hour</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma Prostate</u>		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>than 7 yrs.</u>	
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>11-2-1967</u> to <u>12-5-1969</u> , that (I) (we) last saw the deceased alive on <u>12-5-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Zaher Ahmad Khan</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Zaher Ahmad Khan</u>				23D. ADDRESS <u>Lutheran Hospital</u>	
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE <u>12-9-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Abraham's Memorial Pk. Annapolis, Md.</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE RECEIVED BY HEALTH DEPT. <u>DEC 9 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Randolph J. Collick</u>		25D. ADDRESS <u>2431 E. Oliver St.</u>			



$$\frac{35}{99}$$

605

MEDICAL CERTIFICATION

Letter from M.E.'s office

1-27-70

M.H.

211

B-650

1

BALTIMORE CITY HEALTH DEPARTMENT

69 12144 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12144

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JAMES BROWN

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
December 3, 1969 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

1529 E. Preston Street

3. DATE PRONOUNCED DEAD Month Day Year Hour
December 3, 1969 3:10 P. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland

B. COUNTY

808

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Jan 24, 1927

10. AGE (In years
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

1529 E. Preston Street

11. BIRTHPLACE (State or foreign country)

S. C.

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

Robert Brown

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Maintenance

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Alice

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

214-26-2283

18. INFORMANT

Irish Brown

ADDRESS

19.

412.2

CAUSE OF DEATH

Hypertensive cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Extensive pulmonary fibrosis

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 4, 1969

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

Nov 8 / 69

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem

24D. LOCATION (City, town, or county)

Westport

(State)

Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 9 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

William E. Blodgett 11297 Cedar St

ADDRESS

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

REPORT OF

FIELD STATION

NO. 1

DATE

BY

FOR

TO

FROM

BY

FOR

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FROM

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FOR

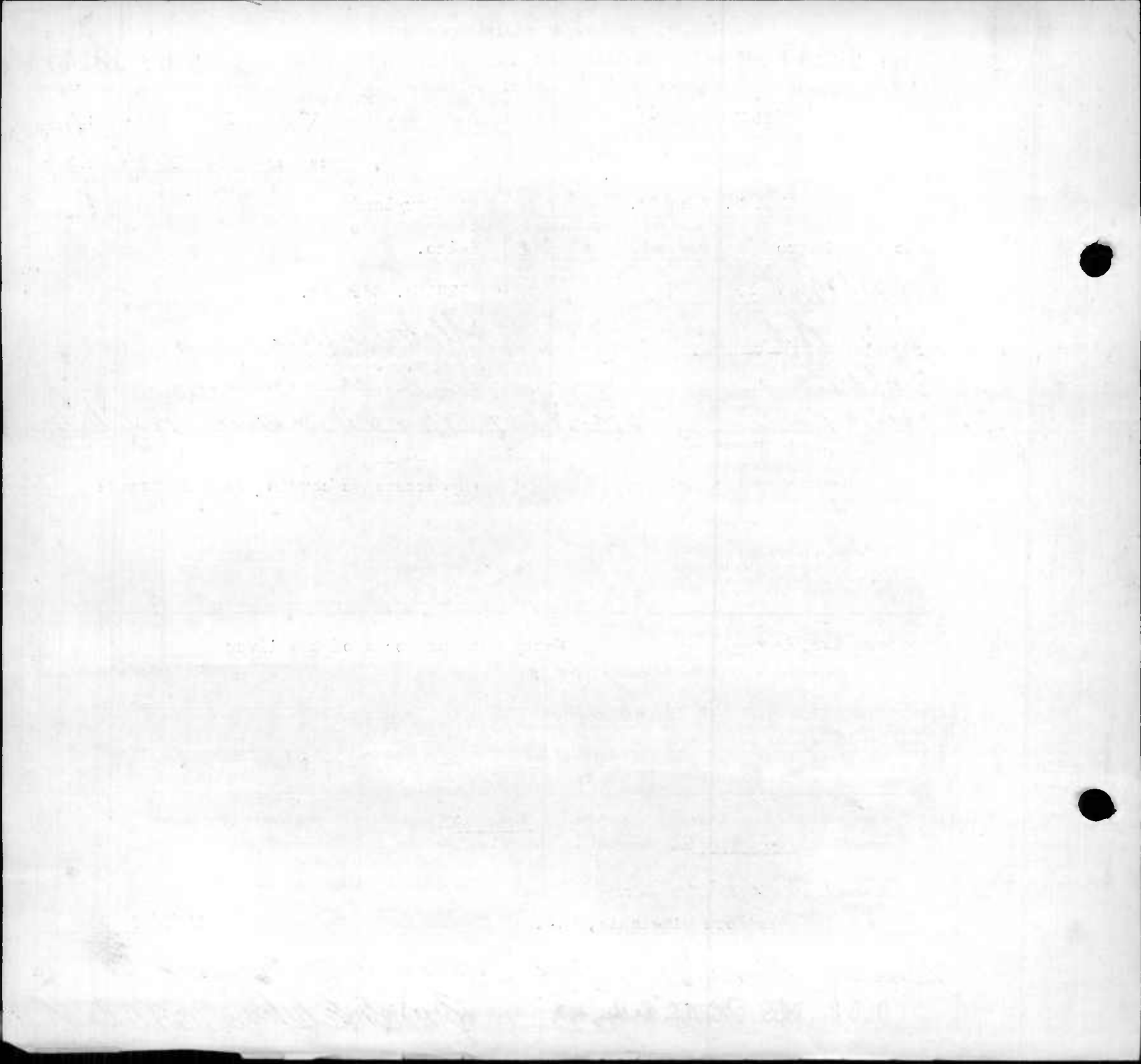
TO

69 12145 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12145

BIRTH NO.

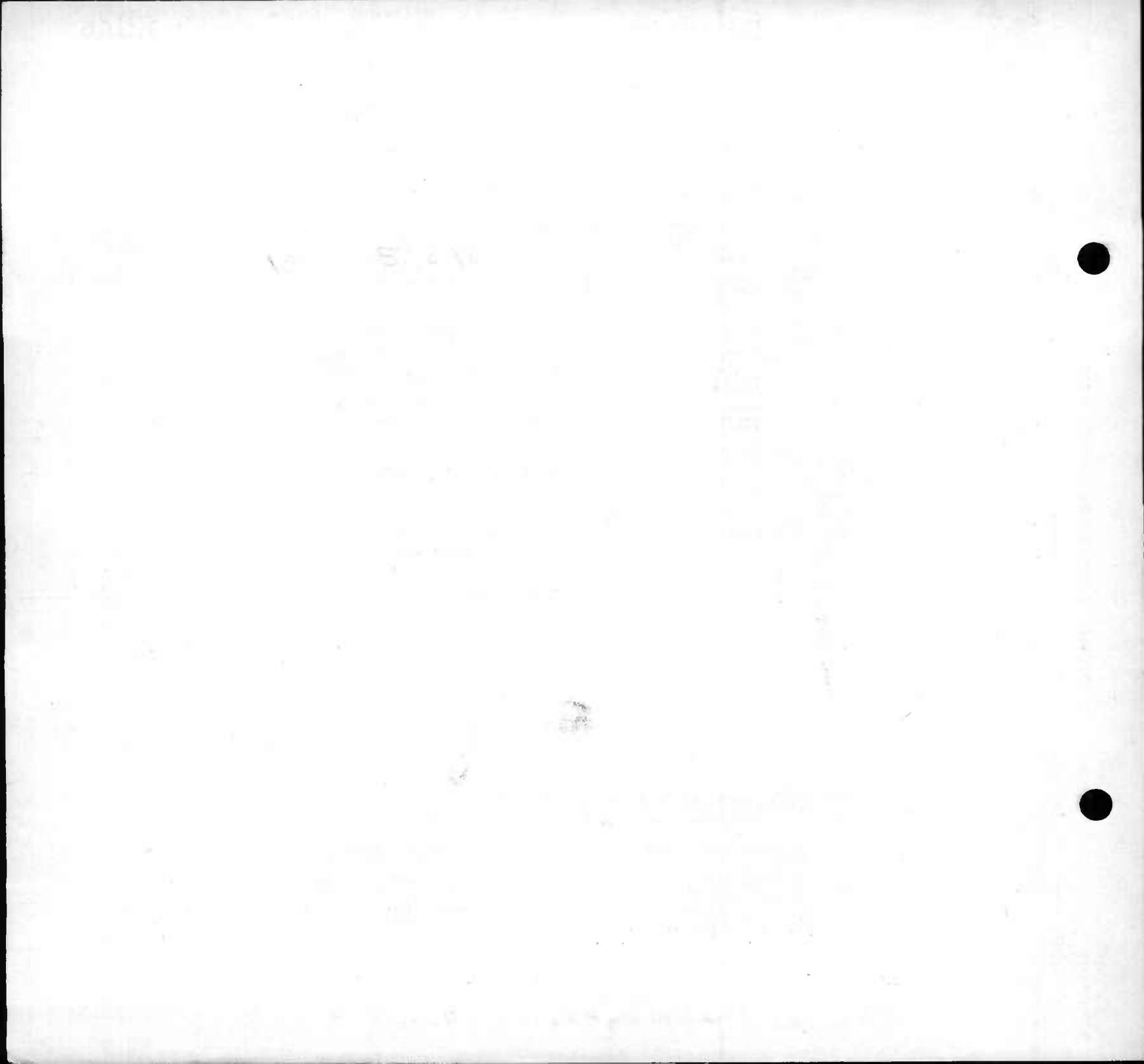
1. NAME OF DECEASED (Type or Print) LEROY WILLIAMS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 5 69 6:52 a.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1201 N. Eden St.		3. DATE PRONOUNCED DEAD Month Day Year Hour December 5, 1969 6:52 a.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH Nov. 21/1932		10. AGE (In years lost birthday) 37	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? Slater Williams	
13. FATHER'S NAME Slater Williams		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	
15. MOTHER'S MAIDEN NAME Nonnie Williams		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean	
17. SOCIAL SECURITY NO. 213-28-2087		18. INFORMANT Nonnie Williams	
19. CAUSE OF DEATH 412.2		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Fatty metamorphosis of the liver		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) YES		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/5/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 10/69	
24C. NAME OF CEMETERY or CREMATORY Good Natl Cem.		24D. LOCATION (City, town, or county) (State) 5501 Fredrick Cr.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Frank Caliskan		ADDRESS 1129 N. Carroll St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12146
69 12146		BIRTH NO.		
1. NAME OF DECEASED (Type or Print) WASHINGTON, SAMUEL Charles		2. DATE AND HOUR OF DEATH 12/6/69 9 45 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HYNNION MEMORIAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 908 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1924 SHERWOOD AVE. BALT. MD 21218		
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/8/18	9. AGE (In years lost birth day) 51
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Shedwick Washington		
14. MOTHER'S MAIDEN NAME CARRIE Mosley		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO. 231-09-3656		17. INFORMANT ADDRESS CARRIE PARKER 1924 SHERWOOD AVE.		
18. 485X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic lung disease & Cor pulmonale Bronchopneumonia		CAUSE OF DEATH Respiratory Failure Chronic lung disease & Cor pulmonale Bronchopneumonia		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4L 0Y		
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11/5 19 69 to 12/6 19 69 , that (I) (we) last saw the deceased alive on 12/6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
23A. SIGNATURE Anne L. Leddy M.D.		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) ANNE L. LEDDY M.D.
23D. ADDRESS Union Memorial Hosp. Conv. Sts.		23E. FUNERAL DIRECTOR Marshall W. Jones, Jr.		
24A. BURIAL CREMATION, REMOVAL (Specify) Transit-burial		24B. DATE 12-10-69		24C. NAME OF CEMETERY OR CREMATORY Shoulders Hill Cemetery
24D. LOCATION Portsmouth, Virginia		24E. ADDRESS 1735 Harford Ave. 21213		
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		



FUNERAL DIRECTOR: IMPORTANT

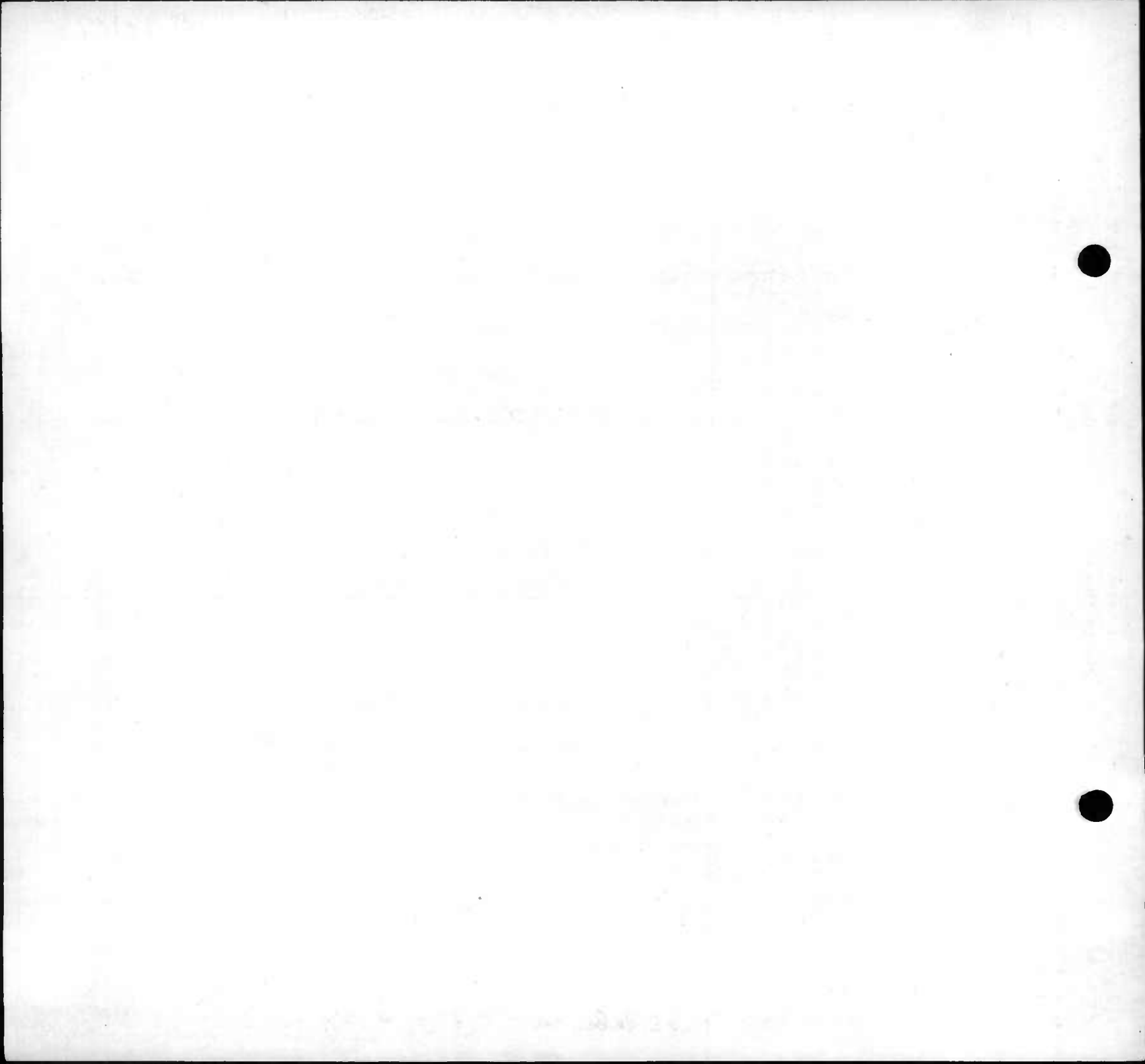
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 12147 CERTIFICATE OF DEATH

REG. NO. 69 12147

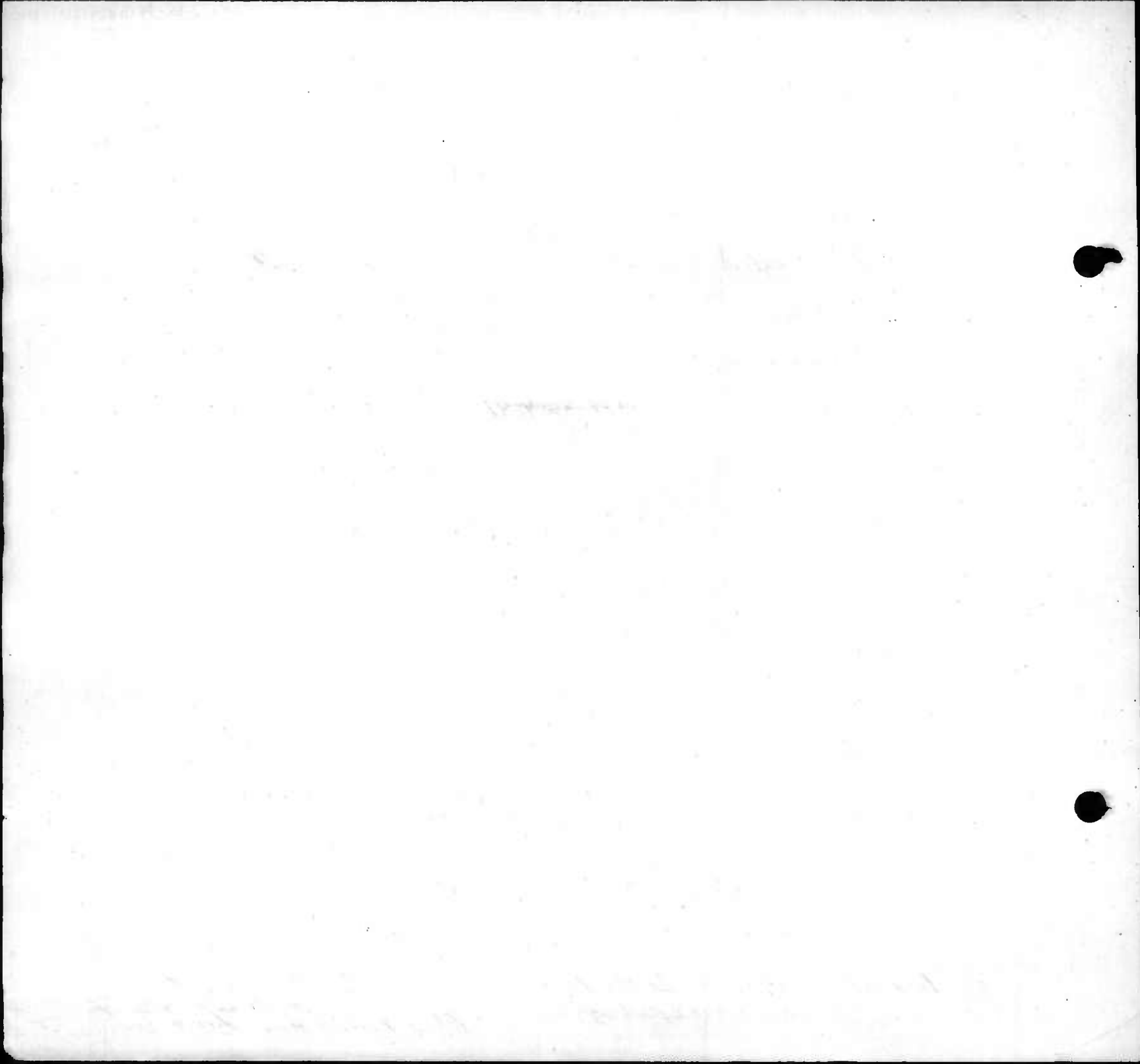
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DAVID A. NEWMAN		2. DATE AND HOUR OF DEATH 12-5-69 7:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 University of Maryland Hosp.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 512 N. ARLINGTON AVE. # 23			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-98	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) U.D.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ABRAHAM NEWMAN		14. MOTHER'S MAIDEN NAME EILEEN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 012-03-2019		17. INFORMANT ADDRESS LOUISE WEEMS - DAUG. - SAME	
18. 444.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic CHF 2° to 3°; COPD		(A) IMMEDIATE CAUSE Thrombosis of femoral artery DUE TO, OR AS A CONSEQUENCE OF: (B) Generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2d U.K.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-5 19 69 to 12-8 19 69 , that (I) (we) last saw the deceased alive on 12-8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Michael G. Hayes, MD				23B. DATE SIGNED 12-8-69	
23C. PHYSICIAN'S NAME (Type) Michael G. Hayes				23D. ADDRESS Univ. of Md. Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-69		24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM.	
24D. LOCATION (City, town, or county) BALTO., Md.		24E. LOCATION (State) _____			
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Geo. W. Nelson	
				ADDRESS F.H. CALHOUN ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12148		BALTIMORE CITY HEALTH DEPARTMENT		69 12148	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HAWKINS, MARY		12-4-69 - 11:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Bolton Hill Nursing Home		A. STATE Md.		B. COUNTY 1702	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1312 EUTAW PL.					
5. SEX Female	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-27-16	9. AGE (In years lost birthday) 83	10. AGE (In years lost birthday) 83
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-38-4891		17. INFORMANT Bolton Hill Nursing Home	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE cerebral thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive C.V. disease (C) UNDERLYING CONDITION last. arteriosclerosis gen		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/1/69 yes years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/7 1969 to 12/4 1969, that (I) (we) last saw the deceased alive on 12/4 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. M. M. M.				23B. DATE SIGNED 12/5/69	
23C. PHYSICIAN'S NAME (Type) ALAN H. MACHT MD				23D. ADDRESS 2 E. Read St Balt Md 21202	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/69		24C. NAME OF CEMETERY OR CREMATORY B.H. N.H. Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Talbot		25C. FUNERAL DIRECTOR Person Funeral Home	
25D. ADDRESS 1300 W. Calhoun St					



BALTIMORE CITY HEALTH DEPARTMENT

69 12149 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12149

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARY E. CHATMAN		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 4 Year 69 Hour 8:25 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2648 W. Franklin St.		3. DATE PRONOUNCED DEAD Month December 4, 1969 Year 8:25 p.m.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1605			
6. SEX Female	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 7-1-28		10. AGE (In years last birthday) 41	
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO.	
18. INFORMANT Buster Chatman		ADDRESS same	
19. 571.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Fatty liver DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Isidore Mihalakis</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Isidore Mihalakis, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12/5/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-8-69	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun St.	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12150

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 12150

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Sarah Murdaugh

2. DATE AND HOUR OF DEATH

12-3-1969

10:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37

Mercy Hospital, Inc.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Md.

1501

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1633 N. Gilmore St.

5. SEX

Female

6. RACE

N

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

4/1/01

9. AGE (In years
last birthday)

68

If Under 1 Yr.

If Under 24 Hrs.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Nelson Marshall

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever In U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL
SECURITY NO.

251120111B

17. INFORMANT

ADDRESS

Annie Jackson 3428 Chessell Court

18.

25091

CAUSE OF DEATH

cardiac decompensation
High degree AV blockAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

C.M.A.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Diabetes Mellitus

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10-31-1969 to 12-3-1969
that (I) (we) last saw the deceased alive on 12-3-1969 and that (in my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

H. MAKIPAU

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

HOUSHANG- MAKIPAU

23D. ADDRESS

24A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

Burial

12-8-69

Mt. Auburn Cemetery

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

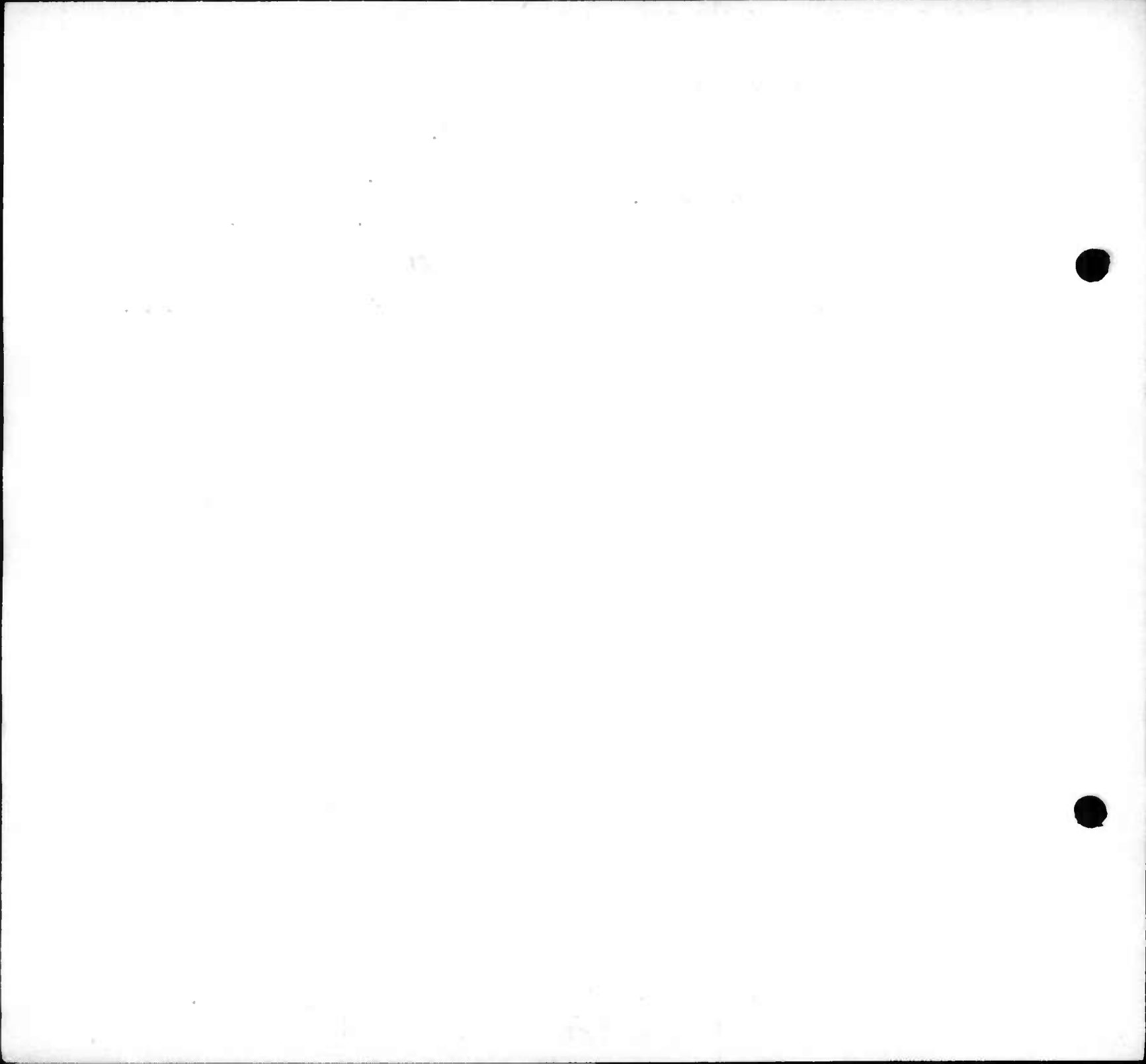
ADDRESS

DEC 9 1969

Robert E. Bailey, M.D.

Nelson F. Bailey

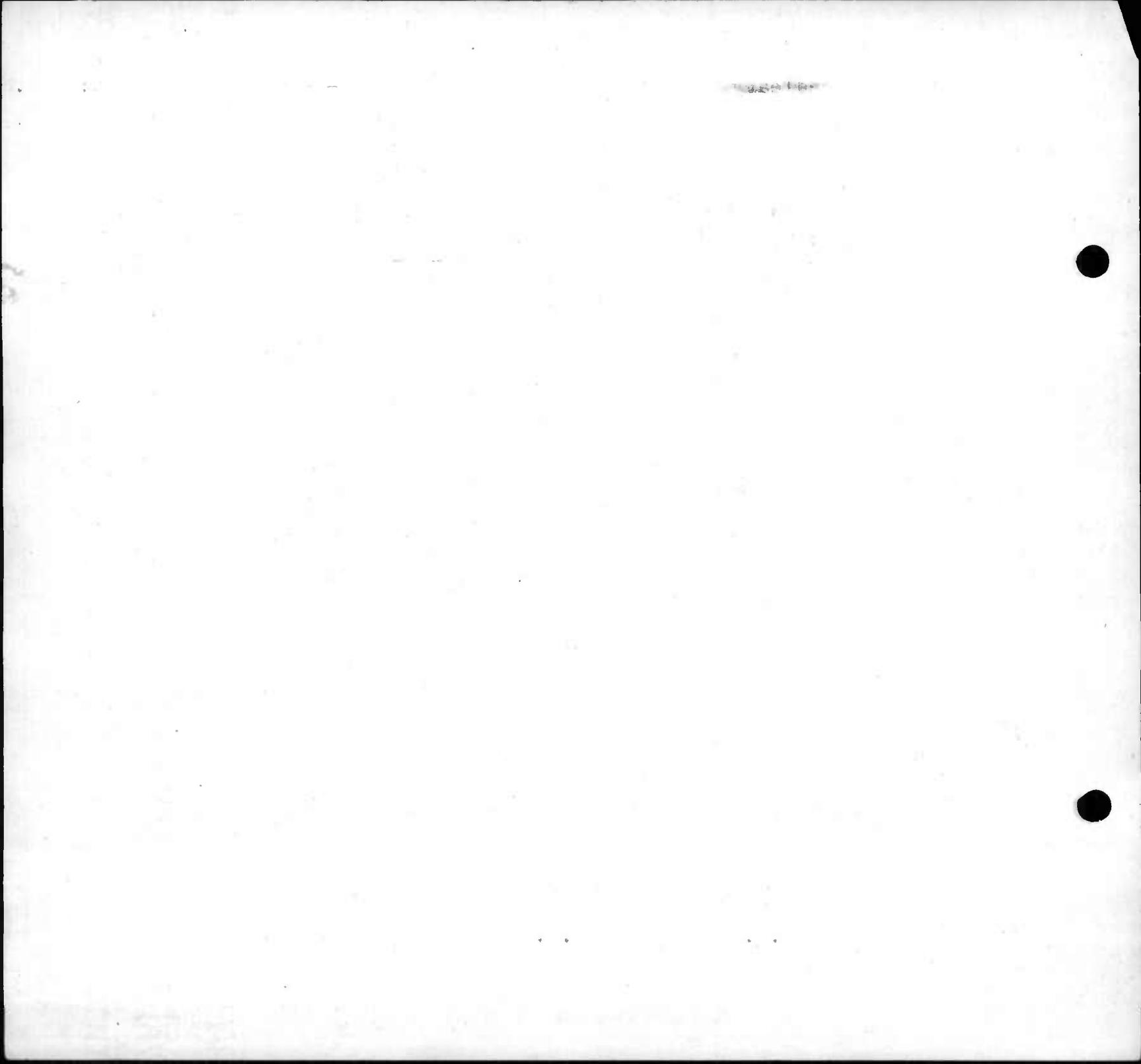
1348 C. Lhoun St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 69-23848-69 12151		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12151	
1. NAME OF DECEASED (Type or Print) Vondleary PAULING				2. DATE AND HOUR OF DEATH 12-6-69 11:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1301 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 808 WHITELOCK STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-05-69	9. AGE (In years last birthday) 1	If Under 1 Yr. Months Days 1	If Under 24 Hrs. Hours Min. 1
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gregory Heath				14. MOTHER'S MAIDEN NAME MARGARET PAULING			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Gregory Heath 920 Chauncey Ave.			
18. 726.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE CARDIO RESP ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) RESP DISTRESS OF NEWBORN DUE TO, OR AS A CONSEQUENCE OF: (C) HYALINE MEMBRANE DIS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 H 26 H 26 H			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that it (this hospital) attended the deceased from DEC 5 19 69 to DEC 6 19 69 , that (I) last saw the deceased alive on DEC 6 19 69 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE G. R. Greene MD				23B. DATE SIGNED DEC 6 '69		23C. PHYSICIAN'S NAME (Type) G. R. GREENE M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL				23E. DATE REC'D BY HEALTH DEPT. DEC 9 1969			
23F. NAME OF REGISTRAR Robert E. Johnson				23G. FUNERAL DIRECTOR V. R. Bailey			
23H. ADDRESS 1348 Calhoun St.				23I. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-69		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12152

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 12152

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Cooper, Harry Milton

2. DATE AND HOUR OF DEATH

12-7-69

8:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Bon Secours Hospital

34

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

1113 SARAHANN Street

5. SEX

Male

6. RACE

Negroid

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

8-12-18

9. AGE (in years last birthday)

51

10. Under 1 Yr. Months

Days

11. Under 24 Hrs. Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Warehouseman

10B. KIND OF BUSINESS OR INDUSTRY

Empire Paper Co.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

America

13. FATHER'S NAME

Harry Cooper

14. MOTHER'S MAIDEN NAME

Laura Haycock

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

216-01-7237

17. INFORMANT

ERMA COOPER-1113 SARAHANN ST. Hospital Admission sheet

ADDRESS

18. 011-2/1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Tuberculous Meningitis. 20 days.

year

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Nov. 22, 19 69 to Dec. 7, 19 69 that (I) (we) last saw the deceased alive on December 7, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Varah Vorasubin M.D.

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

Dec. 7, 1969.

23C. PHYSICIAN'S NAME (Type)

VARAH VORASUBIN M.D.

23D. ADDRESS

Bon Secours Hosp. Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12-11-69

24C. NAME of CEMETERY or CREMATORY

ARBUTUS MEM. PK.

24D. LOCATION

(City, town, or county)

(State)

ARBUTUS, MARYLAND

25A. DATE REC'D BY HEALTH DEPT.

DEC 9

1969

25B. NAME of REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Geyson R. Bailey

ADDRESS

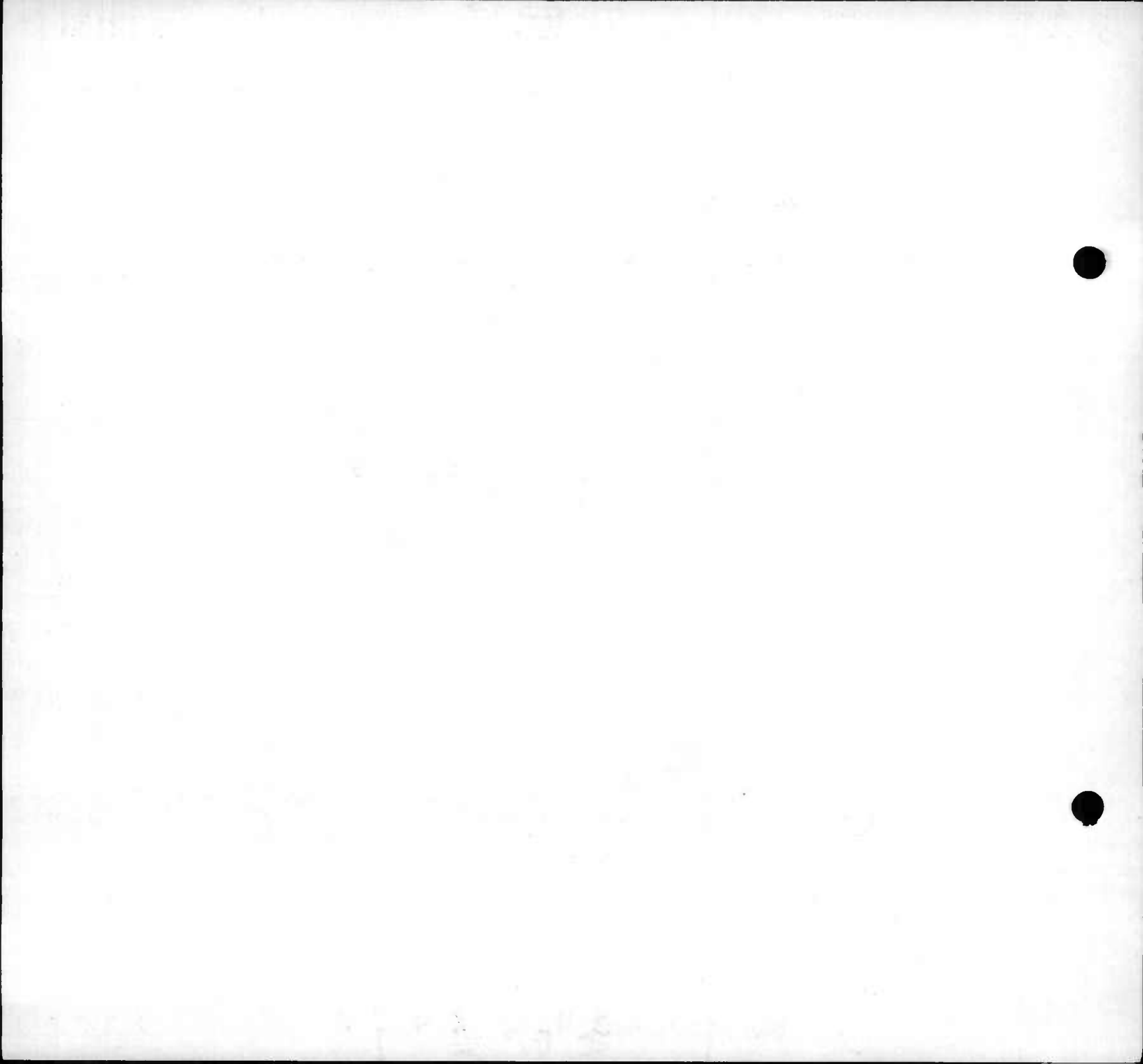
1348 N. Calhoun St.

840

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

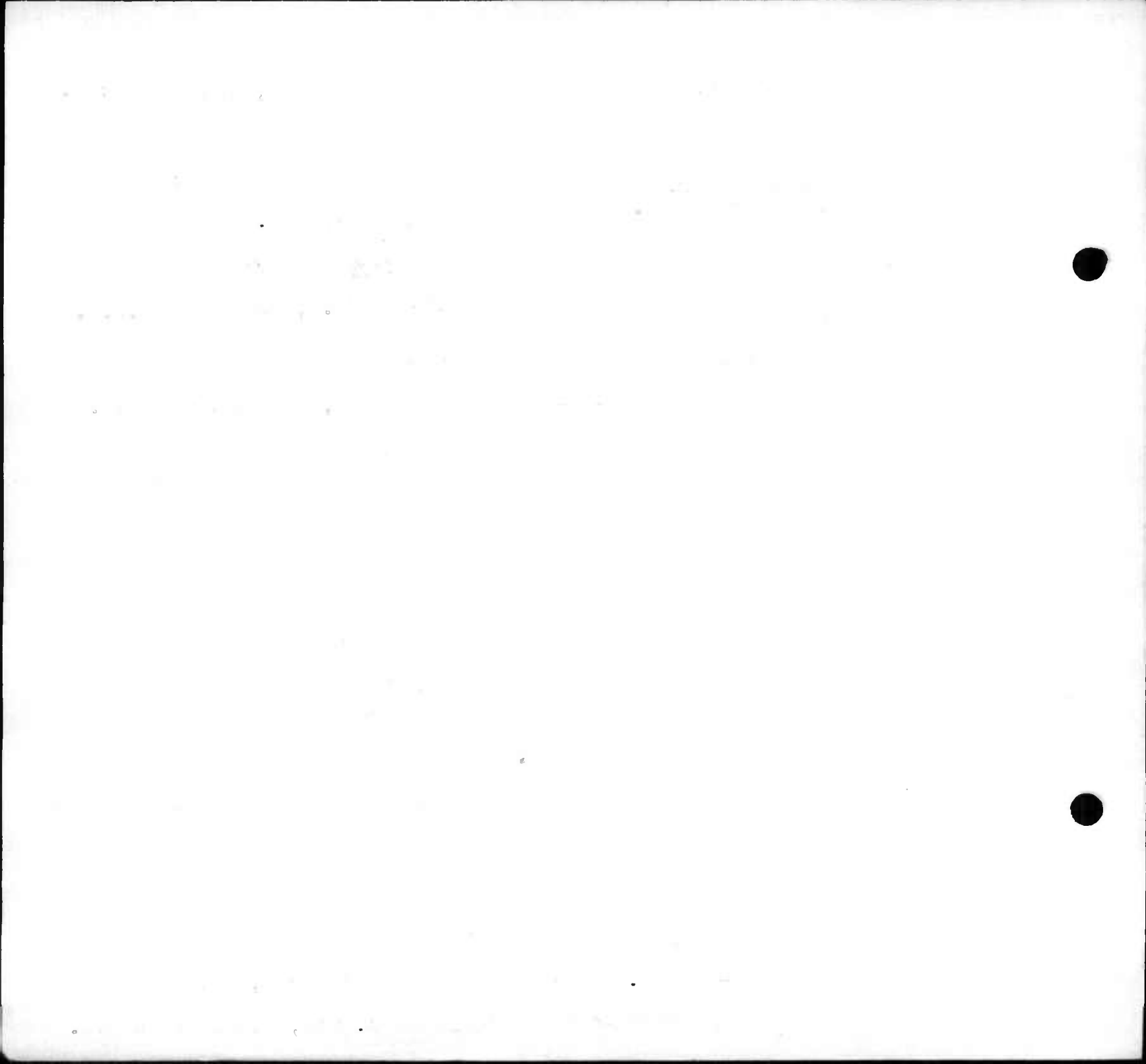
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12153
BIRTH NO. 69 12153		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Shabrook, Henrietta		2. DATE AND HOUR OF DEATH 12, 8, 69 17 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 428imai Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2798		
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 4971 Edgemere St		
5. SEX Female	6. RACE Negroid	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12, 22, 82	9. AGE (In years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Ind.
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Richard T. Medley		14. MOTHER'S MAIDEN NAME Rosie Barnes		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-16-4890		17. INFORMANT Ollie Hicks
		ADDRESS 4971 Edgemere St.		
18. 4 12 21		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CVA		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD, hypertension DUE TO, OR AS A CONSEQUENCE OF:		
		(C) _____		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from June 11, 1965 to Oct 23, 1969 , that (I) (we) last saw the deceased alive on Oct 23, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.				
23A. SIGNATURE E. Altahian				23B. DATE SIGNED 12/8/69
23C. PHYSICIAN'S NAME (Type) E. Altahian				23D. ADDRESS RELSON F. H. 1348 CALHOUN STREET
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-69		24C. NAME of CEMETERY or CREMATORY MY. ZION CEMETERY
24D. LOCATION (City, town, or county) (State) St. Mary's County, Md.				
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Gailley, Md.		25C. FUNERAL DIRECTOR V. R. Bailey



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12154	
69 12154 CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Emma Hunt	
2. DATE AND HOUR OF DEATH December 7, 1969 11: A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Kenson Nursing Home 2922 Arunah Ave.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2001 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1812 penrose Ave.	
5. SEX Female	6. RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/1895 9. AGE (in years last birthday) 74 If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME William Thomas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. MOTHER'S MAIDEN NAME Kate Sullivan		14. INFORMANT ADDRESS Mildred Blue, 1812 penrose Ave.	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-6501	
17. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) Chronic Cardio-Vascular Disease. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		18. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Several years (B) DUE TO, OR AS A CONSEQUENCE OF: (C) Several years	
19. DATE OF OPERATION 0 none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examined)		21B. PLACE OF INJURY (e.g., in or about home, lorn, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 2, 1968 to Dec 7, 1969, that (I) (we) lost saw the deceased olive on Dec 7, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Frank N. Ogden, M.D.		23B. DATE SIGNED Dec. 8, 1969	
23C. PHYSICIAN'S NAME (Type) FRANK N. OGDEN, M.D.		23D. ADDRESS 2701 N. Calvert St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-10-69	24C. NAME OF CEMETERY or CREMATORY Mt. Auburn	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Baker, M.D.	
25C. FUNERAL DIRECTOR Charles R. Law		ADDRESS 802 Madison Ave.	



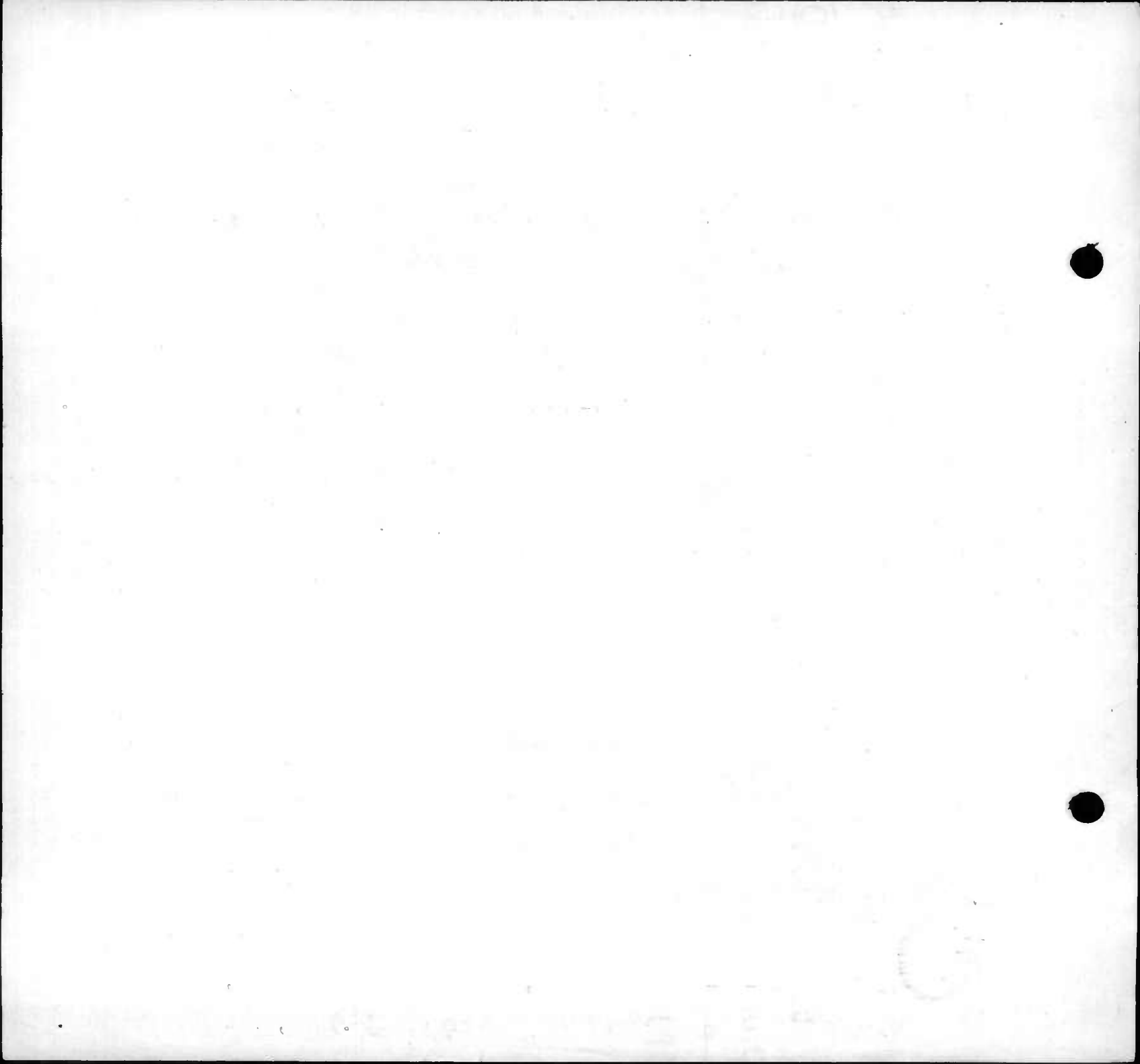
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

69 12155 CERTIFICATE OF DEATH

REG. NO. 69 12155

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Towles, Mercedia</u>		2. DATE AND HOUR OF DEATH <u>12-7-69</u> <u>6:30 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Maryland</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD</u> B. COUNTY <u>1605</u>	
C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>806 Whitmore Ave</u>	
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-24-33</u>	9. AGE (In years lost birthday) <u>36</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Florida</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Freddie Stevenson</u>		14. MOTHER'S MAIDEN NAME <u>Savana Jackson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>267-44-7983</u>		17. INFORMANT ADDRESS <u>Burton Towles, 806 Whitmore Ave.</u>	
18. <u>5-60-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Electrolyte Imbalance</u> (B) <u>Intestinal Obstruction</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> <u>3 days.</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <u>12-6-69</u> to <u>12-7-69</u> , that (I) (we) last saw the deceased alive on <u>12-7-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Rajinderpal Gandhi</u>				23B. DATE SIGNED <u>12-7-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>RAJINDERPAL GANDHI</u>				23D. ADDRESS <u>730 ASHBURTON ST. BALTIMORE MD. 21216</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-11-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore, National</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison Ave.</u>			



J-520 69 12156

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12156

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) OLIVA JONES				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 12 5 69 8:15 a.m.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2867 W. Lafayette Ave.				3. DATE PRONOUNCED DEAD Month Day Year Hour December 5, 1969 8:15 a.m.			
6. SEX Female				7. RACE Negro		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1606	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 4/22/1919		10. AGE (In years last birthday) 50		11. BIRTHPLACE (State or foreign country) N.C.		E. STREET AND NUMBER 2867 Lafayette Ave.	
12. CITIZEN OF USA		13. FATHER'S NAME		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME ANNIE Mae Sutton	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. NONE		18. INFORMANT George Smith		ADDRESS 2867 Lafayette Balto	
19. 134.1 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Peritonitis due to intestinal obstruction ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. annular carcinoma of the rectum OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/9/69		24C. NAME OF CEMETERY or CREMATORY St. Auburn Cemetery Baltimore Md		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Turner		ADDRESS Baltimore	

15-10-50

AIRPORT EXAMINING CERTIFICATE OF BOARD

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-460		69 12157		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12157	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Keller, George			
2. DATE AND HOUR OF DEATH 12-7-69				5 30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 2802			
FULL NAME OF HOSPITAL OR INSTITUTION 90 Mt Sinai Nursing Home 4613 Park Heights Ave Balto Md 21215				C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 4503 Gwynn Oak Ave							
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-3-88	
9. AGE (In years last birthday) 81		If Under 1 Yr. Months: Days: Hours: Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EXECUTIVE		10B. KIND OF BUSINESS OR INDUSTRY Auto	
11. BIRTHPLACE (State or foreign country) Penna				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Keller				14. MOTHER'S MAIDEN NAME Emile Keller			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.I				16. SOCIAL SECURITY NO. 577-10-3136		17. INFORMANT N.A. Records	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinoma of Stomach - Metastatic ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 months			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 19 57 to Dec 7 19 69 that (I) <input checked="" type="checkbox"/> last saw the deceased alive on Dec 4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Daniel Bakal MD				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-7-69	
23C. PHYSICIAN'S NAME (Type) DANIEL BAKAL MD				23D. ADDRESS 3600 Loch Raven Dr Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Rem.-Burial		24B. DATE 12-8-69		24C. NAME OF CEMETERY or CREMATORY Arlington		24D. LOCATION (City, town, or county) (State) Drexel Hill Pa.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969				25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR ADDRESS H.W. Jenkins & Sons Co., Balto., Md.	

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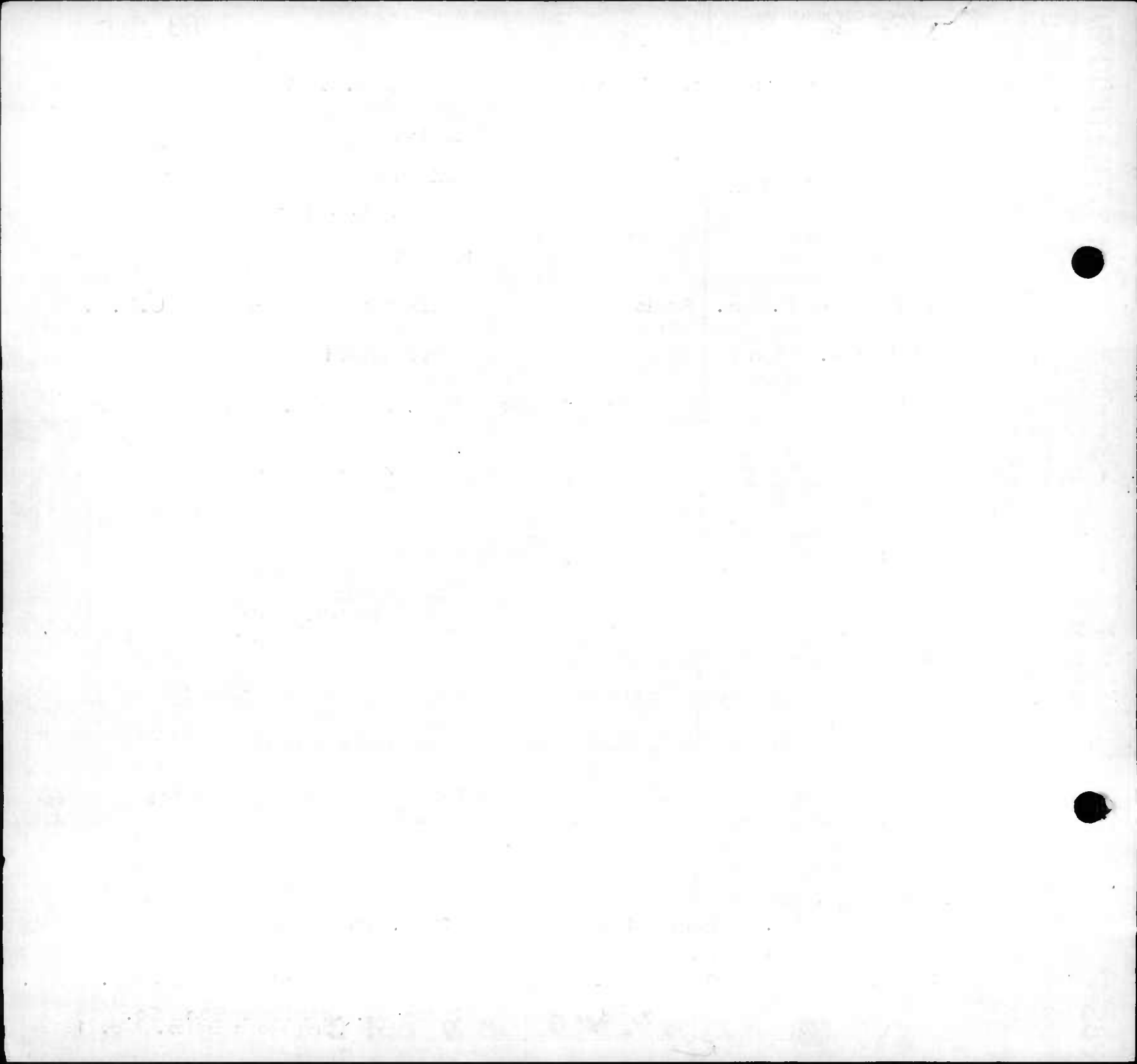
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

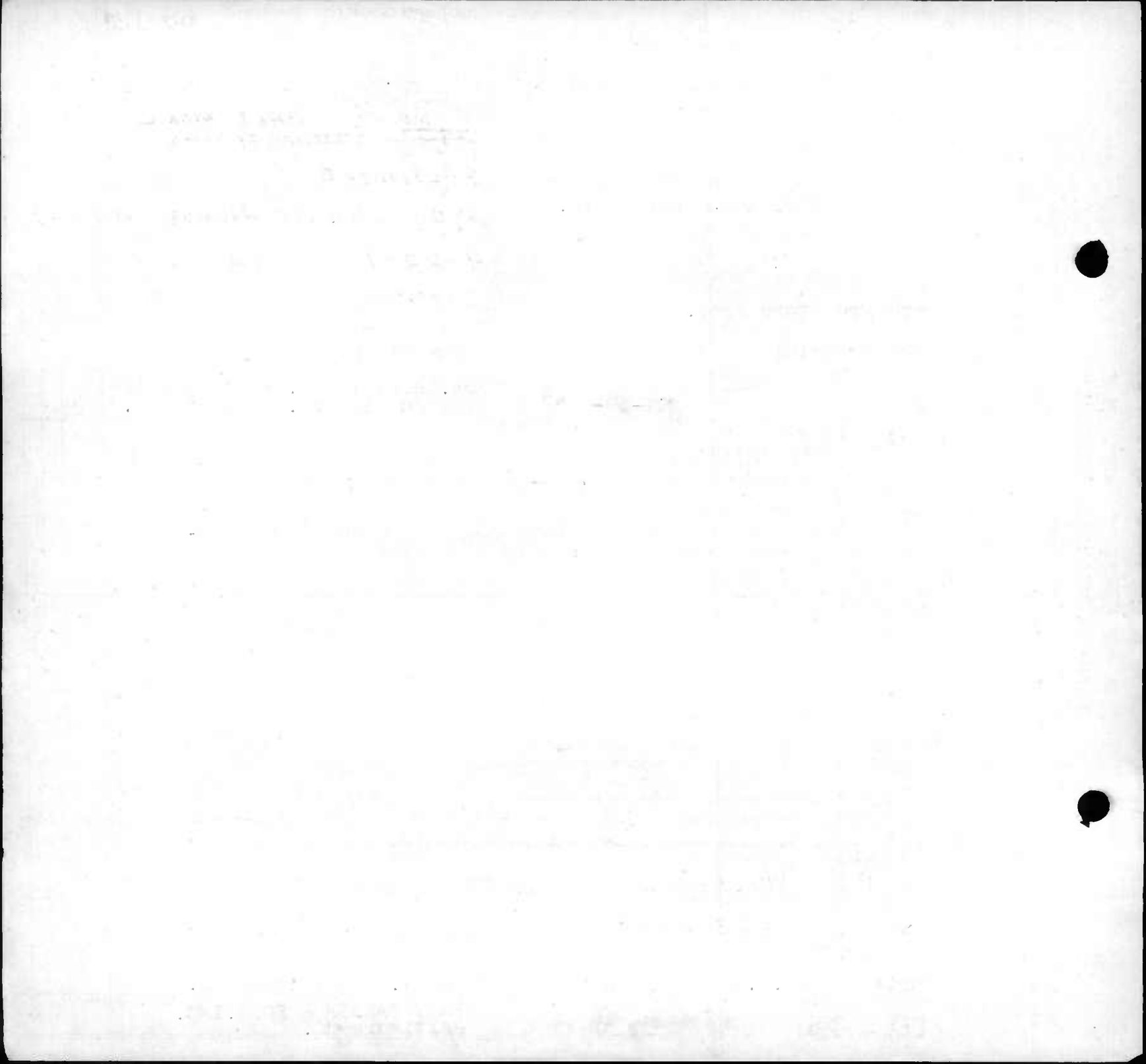
W-256		69 12158		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12158	
BIRTH NO.				2			
1. NAME OF DECEASED (Type or Print) Robert Edward Wagner				2. DATE AND HOUR OF DEATH Dec. 6, 1969 8:22 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 Keswick Home				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2713 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 600 Edgevale Road			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-30-1908	9. AGE (In years lost birthday) 60	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Clerk F.Mge.			10B. KIND OF BUSINESS OR INDUSTRY Radio		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William R. Wagner				14. MOTHER'S MAIDEN NAME Anna Newkirk			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 215-07-9483		17. INFORMANT Mrs. Robert E. Wagner		ADDRESS Same
18. <i>483 X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Bronchopneumonia</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>Unknown disease of brain, leading to severe mental changes, fatty weight loss</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>	
				19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Unknown disease of brain, leading to severe mental changes, fatty weight loss</i>	20A. AUTOPSY? (Yes or No) <i>Yes</i>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>11/5</i> 19 <i>69</i> to <i>12/6</i> 19 <i>69</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>12/6</i> 19 <i>69</i> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>W.B. Daniels, Jr. M.D.</i>				23B. DATE SIGNED <i>12/8/69</i>		23C. PHYSICIAN'S NAME (Type) Dr. Worth Daniels	
23D. ADDRESS 11 E. Chase Street, Baltimore, Md. 21202				23E. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-1969		24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		24D. LOCATION (City, town, or county) (State) Pikesville, Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR <i>Robert E. Jenkins</i>		25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-254		69 12159		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12159	
BIRTH NO.		1. NAME OF DECEASED (JOHN LUTHER SUSEMIHL) (Type or Print) <u>SUSEMIHL, JOHN LUTHER</u>				2. DATE AND HOUR OF DEATH <u>5th December 1969 12.15 p. m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <u>MD.</u> B. COUNTY <u>BALTIMORE</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
45		Good Samaritan Hospital 5601 Loch Raven Blvd.		2920 SUMMITT AVE 5300		E. STREET AND NUMBER		2920 SUMMITT AVENUE 21234	
5. SEX <u>m</u>	6. RACE <u>w.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-22-97</u>		9. AGE (In years last birthday) <u>72</u>		10. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hardware Store Prop.</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Susemihl</u>				14. MOTHER'S MAIDEN NAME <u>Ida Virginia Herold</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-03-5547 A</u>		17. INFORMANT ADDRESS <u>Mrs. Geraldine G. Susemihl (wife) 2920 Summit Ave. Baltimore Md. 21234</u>			
18. <u>436.7 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CAUSE OF DEATH</u>				(A) IMMEDIATE CAUSE <u>Cerebrovascular Accident.</u> DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <u>Arteriosclerotic vascular disease.</u> DUE TO, OR AS A CONSEQUENCE OF:					
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Urinary Tract Infection</u>									
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>NO.</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) <u>NO.</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NO.</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO.</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO.</u>				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>NO.</u>			
22. I certify that <u>my</u> (this hospital) attended the deceased from <u>8/20/1969</u> to <u>12/5/1969</u> , that (I) <u>we</u> last saw the deceased alive on <u>12/5/1969</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>we</u> (did) <u>did not</u> view the body after death.									
23A. SIGNATURE <u>D.H. Sherbourne</u>						23B. DATE SIGNED <u>12/5/69</u>			
23C. PHYSICIAN'S NAME (Type) <u>D.H. SHERBOURNE</u>						23D. ADDRESS <u>Good Samaritan Hospital 5601 Loch Raven Blvd. Balto. 21212.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>Dec. 8. 1969</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1969</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>HENRY SANDER & SONS, INC.</u>		ADDRESS <u>Baltimore Md.</u>	



G-650

69 12160

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12160

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Edith Green				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 820 Summerset St.				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 7 1969 10:10 A.M.			
6. SEX Female				7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12-21-1918				10. AGE (In years lost birthday) 50		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF U.S.A.				13. FATHER'S NAME Thomas Schofield		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1002	
15. MOTHER'S MAIDEN NAME Alma Schofield				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.			
17. SOCIAL SECURITY NO. 217-14-9298				18. INFORMANT ADDRESS Mrs. Alma Schofield 1723 E. Lafayette Ave			
19. 430.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Subdural hemorrhage (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: rupture of cerebral aneurysm (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. DATE SIGNED 12-8-69							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-12-69		24C. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens Street	

Somerset St.

P-626 69 12161

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12161

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

E.

Robert Parker

2. DATE

Known ☐

Month

Day

Year

Hour

OF

Estimated ☐

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital (DOA)

3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

12

7

1969

9:17

A.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Md.

B. COUNTY

6. SEX

Male

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

10-15-1932

10. AGE (In years
last birthday)

37

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

3517 Springdale Ave.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF

WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert E. Parker

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truck driver

14B. KIND OF BUSINESS OR INDUSTRY

Fleetway Transfer Co.

15. MOTHER'S MAIDEN NAME

Annie Mae Jackson

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL

SECURITY NO.

218-28-5006

18. INFORMANT

ADDRESS

Mrs. Irene Parker

3517 Springdale Avenue

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Acute myocarditis
DUE TO, OR AS A CONSEQUENCE OF:(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-8-69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-11-69

24C. NAME of CEMETERY or CREMATORY

Mount Auburn Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 9 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

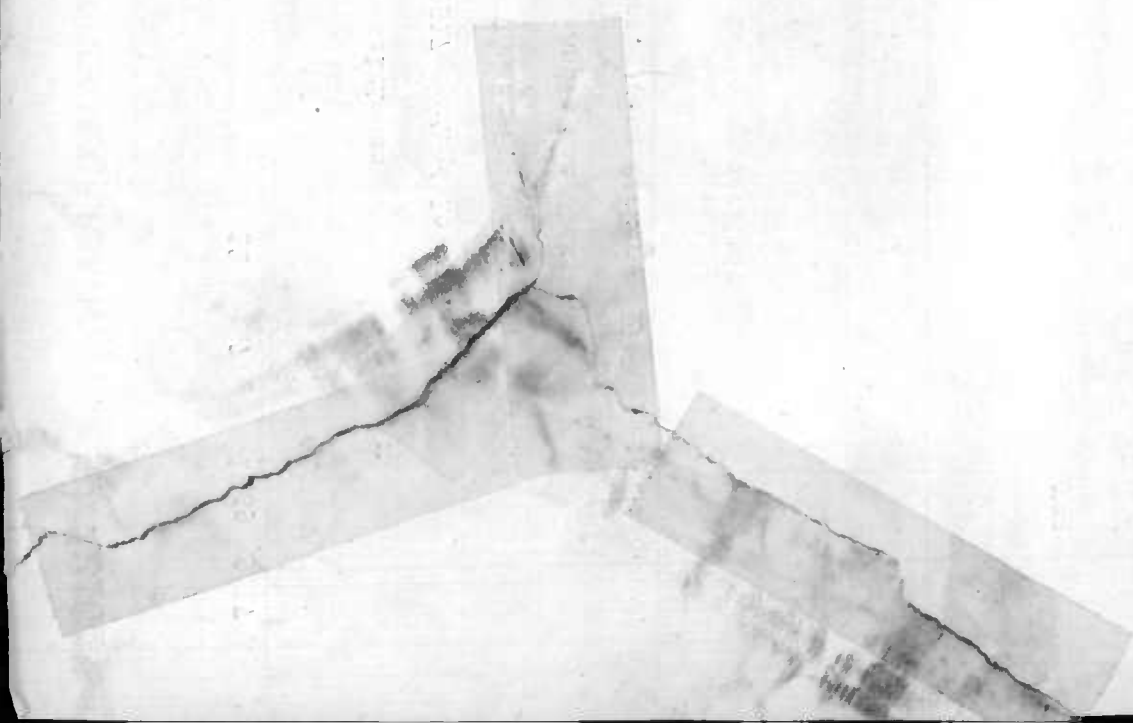
MORTON & DYETT F.H. 1701 Laurens Street

Letter from M.E.'s office

1-19-70

M.H.

VALLEY POWER
VALLEY FORCE
VALLEY CONTENT



B-400

69 12162

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12162

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ella L. Bailey

2. DATE
OF
DEATHKnown ☐ Month Day Year HourEstimated ☐

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Bon Secours Hosp. (DOA)

3. DATE
PRONOUNCED DEADMonth Day Year Hour
12 8 1969 11:50A M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

2002

6. SEX

7. RACE

B. MARRIED ☐ NEVER MARRIED ☐

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Female

Negro

WIDOWED ☒ DIVORCED ☐

Balto.

YES ☒ NO ☐

9. DATE OF BIRTH

7-29-1893

10. AGE (In years
lost birthday)

76

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2112 W. Saratoga St.

11. BIRTHPLACE (State or foreign country)

Richmond, Virginia

12. CITIZEN OF
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Danbridge Steven

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Domestic Work

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Caroline Minor

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No.

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mr. John Doyle 1213 Woodington Road

19. 412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g.,
heart failure, osteoarthritis, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

22F. HOW DID INJURY OCCUR?

m. WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-8-69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-13-69

24C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 9 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

MORTON & DYETT F.H. 1701 Laurens St.

01111

01111

01111

01111

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01111

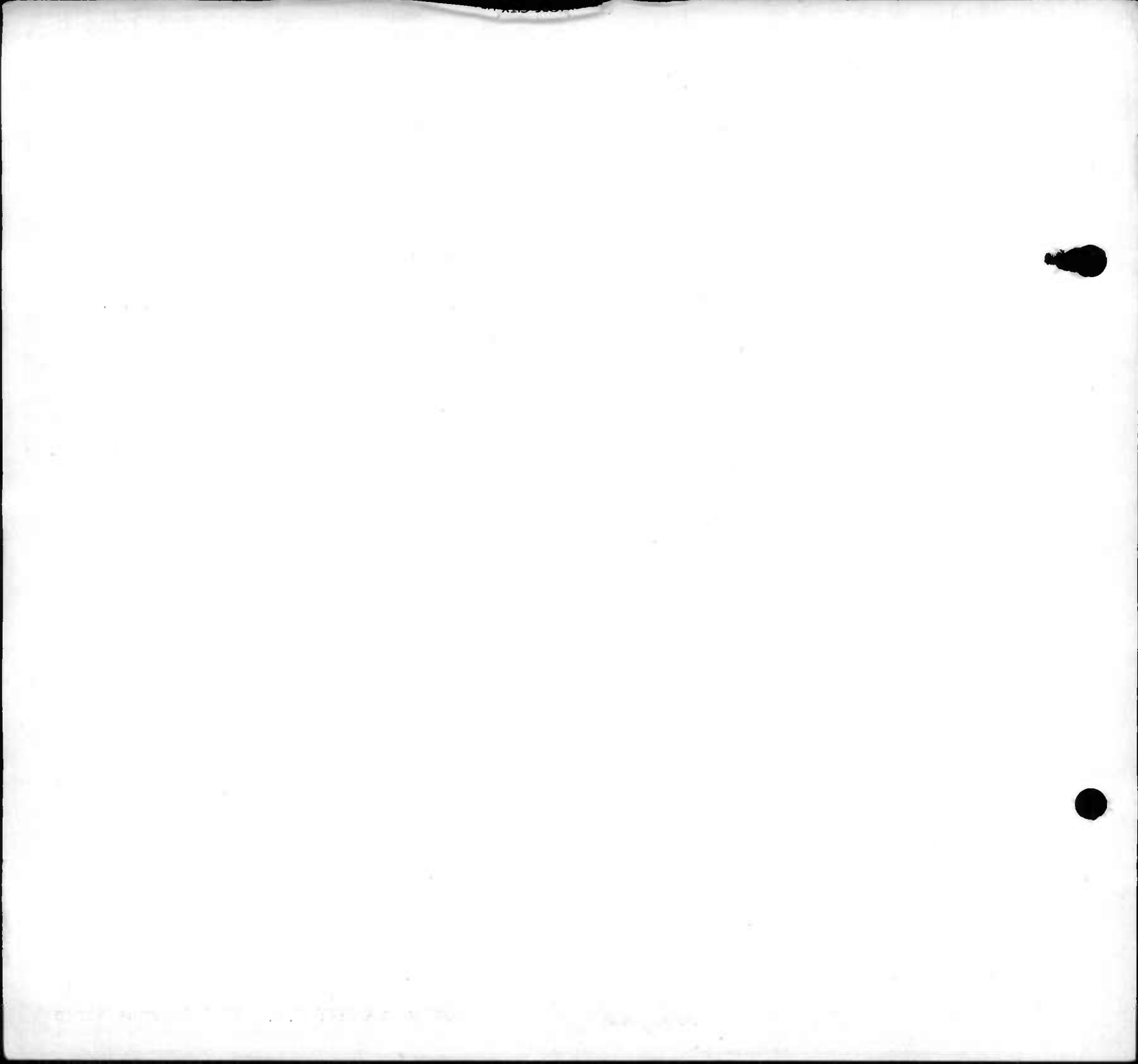
01111

01111

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

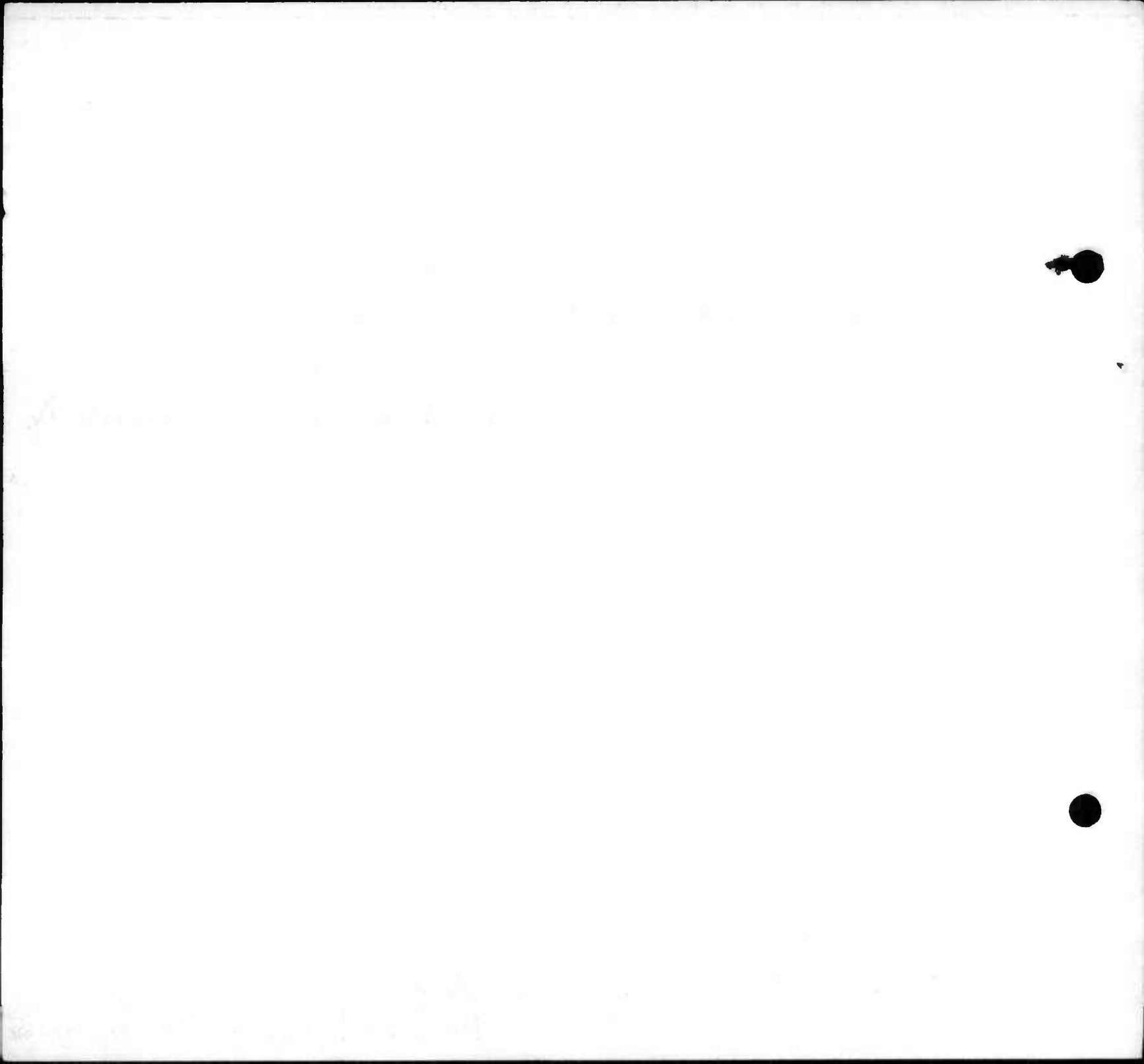
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 69 12163	
1. NAME OF DECEASED (Type or Print)		LEONARD E. WHITING		2. DATE AND HOUR OF DEATH December 5, 1969	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 746 Grantley Street		A. STATE MARYLAND B. COUNTY 1608			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 746 Grantley Street			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 11-18-1917	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10B. KIND OF BUSINESS OR INDUSTRY Steel Eastern Stainless		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Murray Whiting		
14. MOTHER'S MAIDEN NAME Blanche West			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 8/14/44-12/18/45		
16. SOCIAL SECURITY NO. 217-01-1953			17. INFORMANT Mrs. Louise Whiting		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Bronchogenic Carcinoma Chronic metastatic			INTERVAL BETWEEN ONSET AND DEATH 6 months		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 6-6-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6-6-69 to 12-5-69 , that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Bernard S. Karpas Jr.				23B. DATE SIGNED 12-8-69	
23C. PHYSICIAN'S NAME (Type) BERNARD S. KARPAS JR.				23D. ADDRESS 514 Medical Arts Bldg. Balto Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-69		24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.	
				ADDRESS 1701 Laurens Street	



FUNERAL DIRECTOR: IMPORTANT

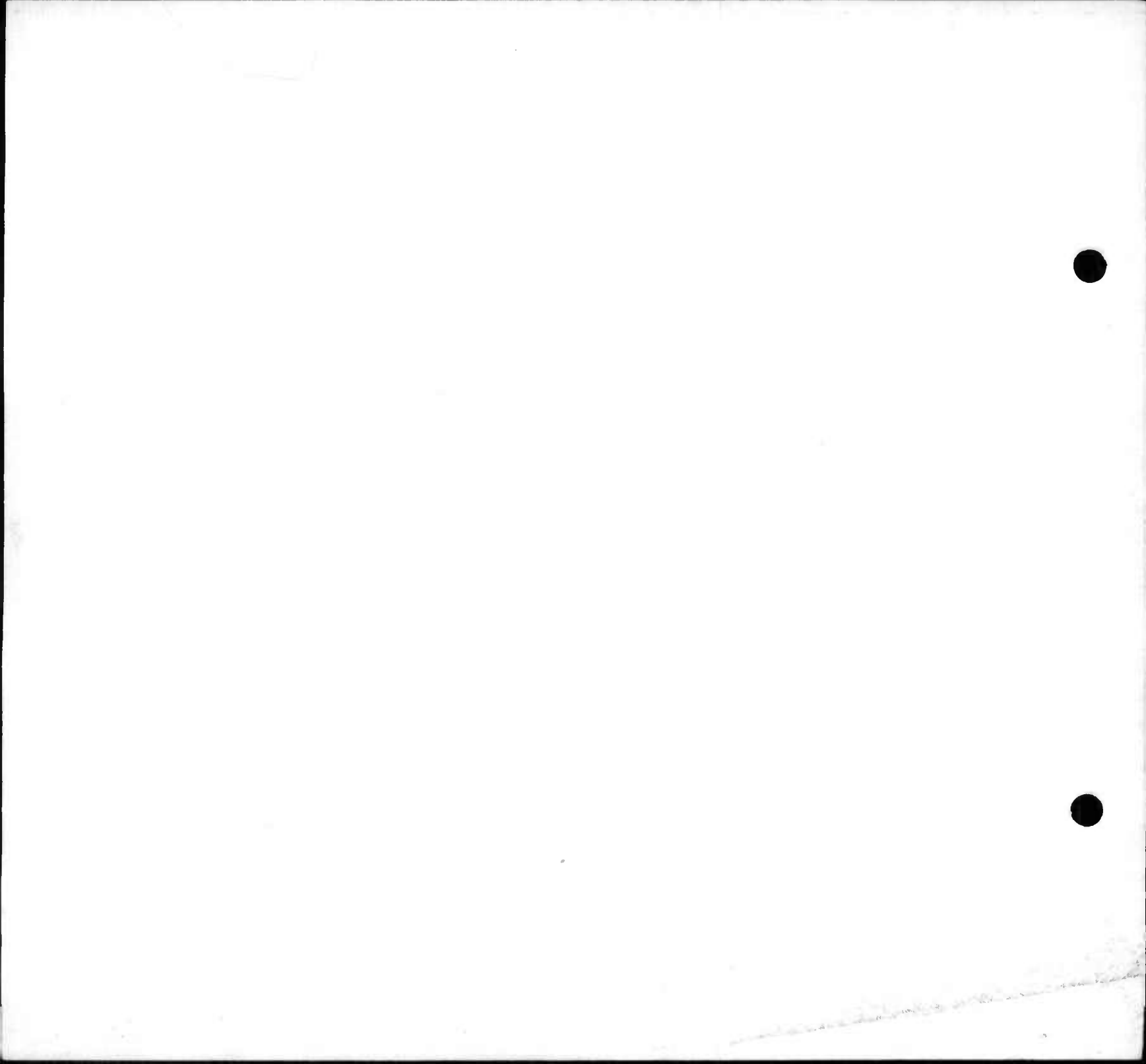
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12164	
J-520 69 12164 CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) JAMES EDW. JONES			2. DATE AND HOUR OF DEATH 12-6-69 11:30 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIV. HOSP			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1538		
			C. CITY OR TOWN BALTO		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 2931 ALLENDALE RD 21216		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-47	9. AGE (In years last birthday) 22	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10B. KIND OF BUSINESS OR INDUSTRY A. Holm & Co.		11. BIRTHPLACE (State or foreign country) MD, Baltimore	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Ned Jones			14. MOTHER'S MAIDEN NAME Grace Stephenson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Linda Jones	
				ADDRESS 2914 Ellicott Dr.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Artery 2° Vent. Fibr. + other Vent. arrhythmias (B) Chronic Renal Failure 2° chronic glomerulonephritis DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertensive CV Disease		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/4 19 69 to 12/6 19 69 that (I) (we) last saw the deceased alive on 12/6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. Schlosberg			23B. DATE SIGNED 12-6-69		
23C. PHYSICIAN'S NAME (Type) B. SCHLOSSBERG MD			23D. ADDRESS UNW Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/69		24C. NAME OF CEMETERY OR CREMATORY Carver Mem. Park	
24D. LOCATION (City, town, or county) (State) Laurel Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 9 1969		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR Morford Dgett F.H.	
				ADDRESS 1701 Laurens St.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

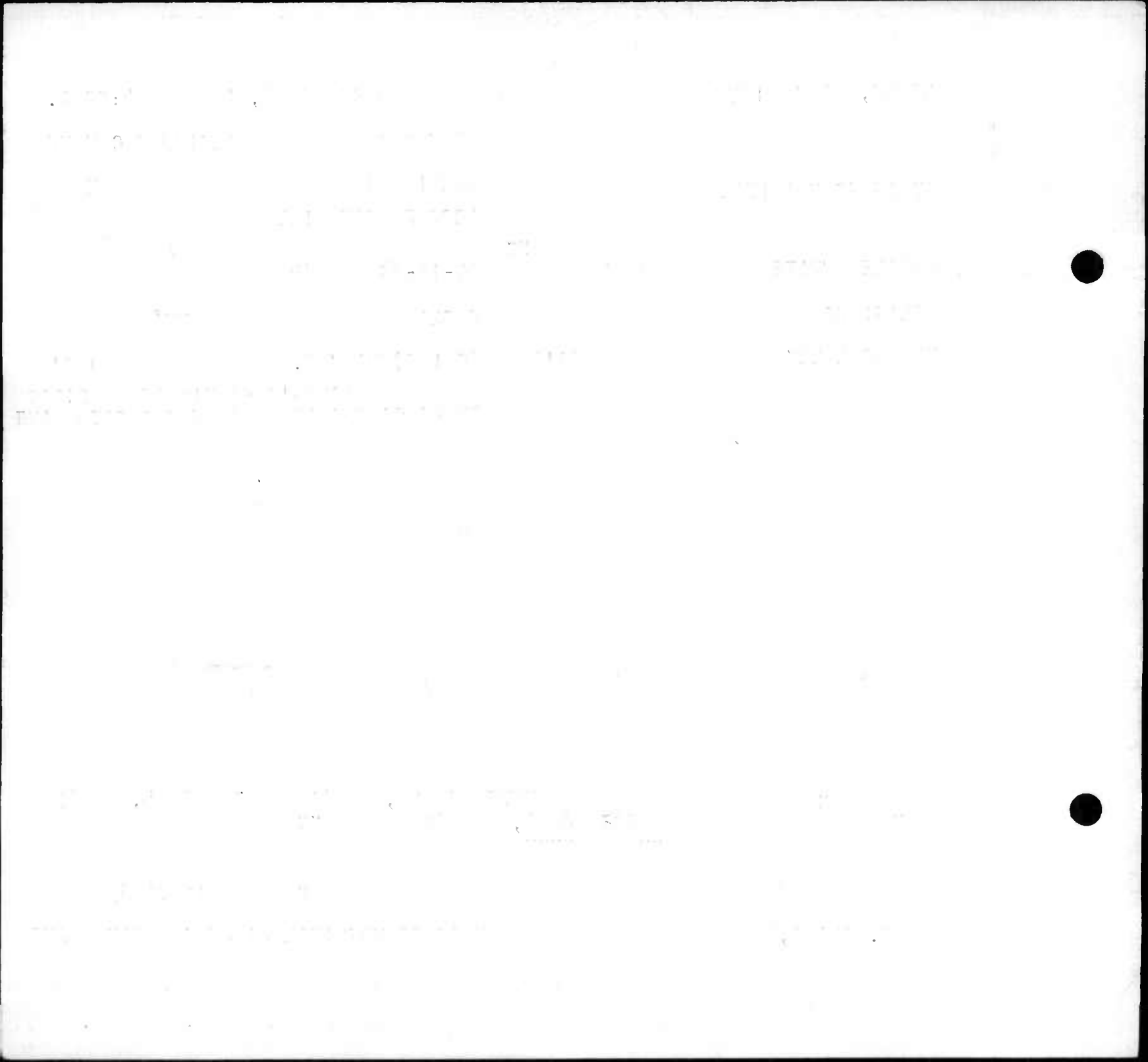
B-630		69 12165		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12165	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) <u>Booker T. Byrd</u>				2. DATE AND HOUR OF DEATH <u>12/3/69</u> <u>10²⁵ P.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1602</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u> <u>38</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u> 6. RACE <u>N</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>11/15/14</u>		9. AGE (In years last birthday) <u>55</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Steward</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>S. Carolina</u>	
13. FATHER'S NAME <u>Andrew Byrd</u>				14. MOTHER'S MAIDEN NAME <u>unk.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>R18-07-3491</u>		17. INFORMANT <u>Mrs Booker Byrd</u>	
18. <u>441.01</u> CAUSE OF DEATH				ADDRESS <u>SA</u>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Aspiration Pneumonia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
				(B) <u>Dissecting Aortic Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>2 wks</u>	
				(C) <u>Hypertensive Vascular Disease</u>		<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(D) <u>Acute Renal Failure</u>		<u>2 wks</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/22</u> 19 <u>69</u> to <u>12/3</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/3</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Richard H. Baum M.D.</u>				23B. DATE SIGNED <u>12/3/69</u>			
23C. PHYSICIAN'S NAME (Type) <u>Richard H. Baum M.D.</u>				23D. ADDRESS <u>University of Maryland Hospital / Baltimore</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/8/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 9 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Barton D. Dgett</u>		ADDRESS <u>1701 Laurens St</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

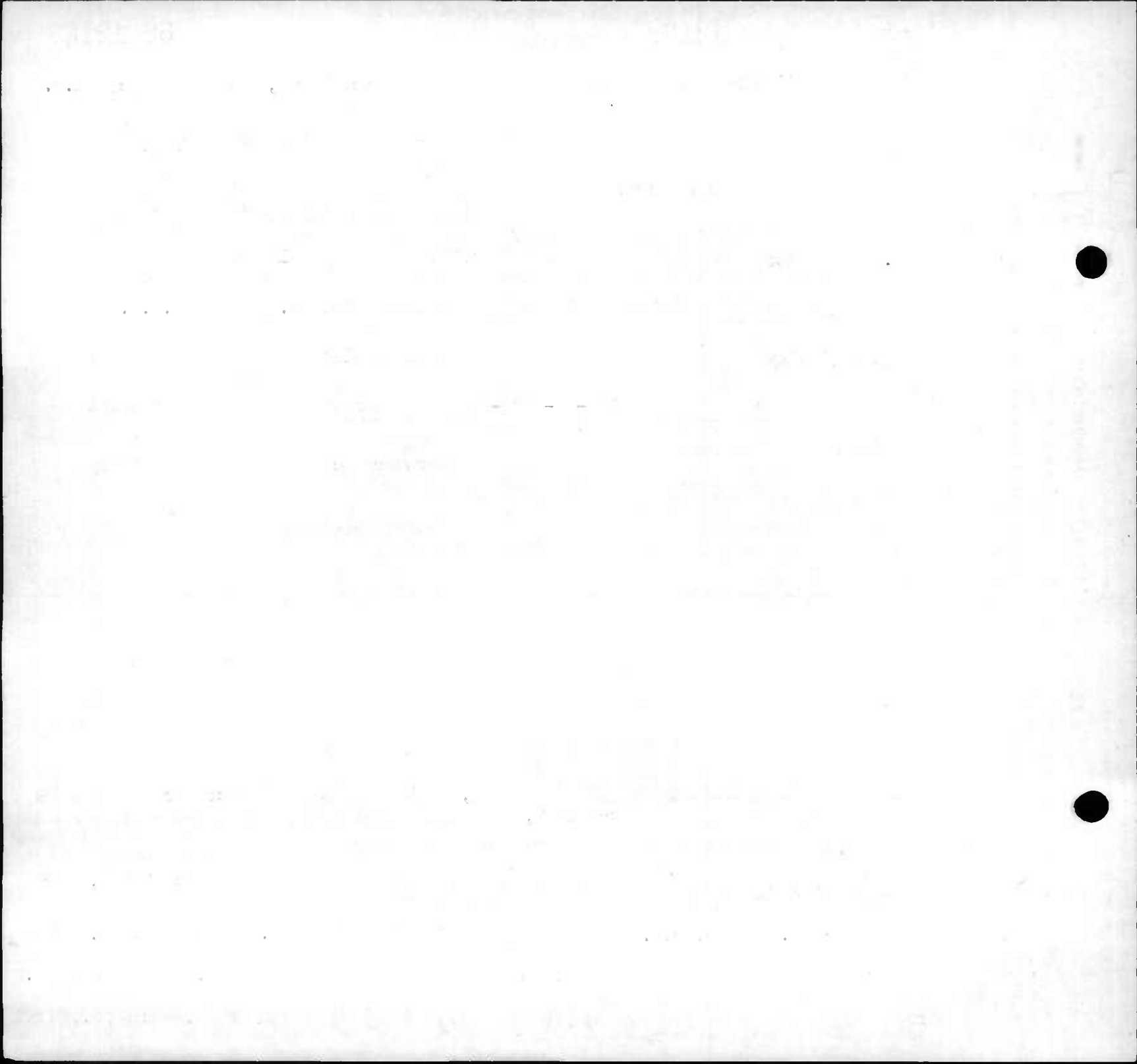
BALTIMORE CITY HEALTH DEPARTMENT		69 12166		69 12166	
BIRTH NO.		L-400		REG. NO.	
1. NAME OF DECEASED (Type or Print) LALLY, MARY SISTER (SISTER MARY LALLY)			2. DATE AND HOUR OF DEATH DECEMBER 4, 1969 4:05 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY		
5. SEX FEMALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 07-16-05 9. AGE (In years last birthday) 64 10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RELIGIOUS			11. BIRTHPLACE (State or foreign country) ENGLAND		
13. FATHER'S NAME THOMAS LALLY DEC 'D			12. CITIZEN OF WHAT COUNTRY? USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			14. MOTHER'S MAIDEN NAME (CAINE) MARY A. DEC 'D		
16. SOCIAL SECURITY NO.			17. INFORMANT RECORD 'S BALTIMORE MD 21229 ST AGNES HOSPITAL WILKENS & CATON AVE		
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) acute Myocardial infarction ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. C. V. A. A. S. C. V. D. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 28, 1969 to DECEMBER 4, 1969 that (X) (we) last saw the deceased alive on DECEMBER 4, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A. Shams, M.D.</i>				23B. DATE SIGNED 12-04-69	
23C. PHYSICIAN'S NAME (Type) A. SHAMS, MD				23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/6/69		24C. NAME OF CEMETERY or CREMATORY Villa St. Michael on grounds of Seton Inst. 6400 Wabash Av	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Sabin, M.D.		25C. FUNERAL DIRECTOR STEWART & MCQUEEN CO.	
				ADDRESS 108 W. North Av., Cityl	



FUNERAL DIRECTOR: IMPORTANT

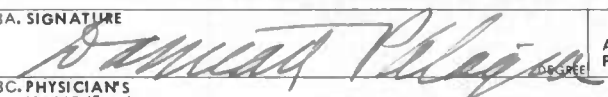
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

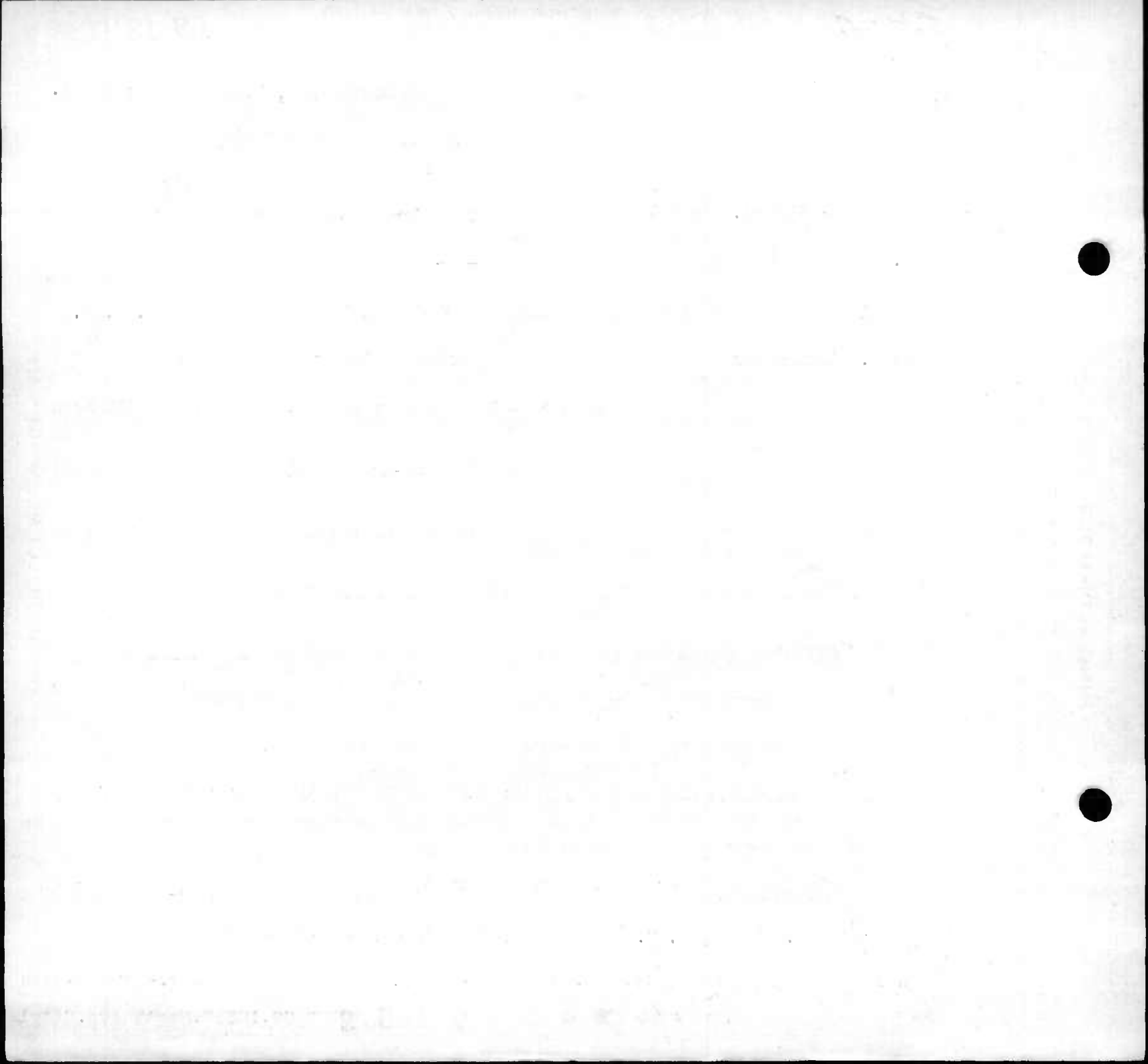
L-534 69 12167		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12167	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Sister Edith Lindley		December 4, 1969 3:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 94 Villa Saint Michael		A. STATE Maryland		B. COUNTY Baltimore City 2841	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4000 Forest Hill Road			
5. SEX F.	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/88	9. AGE (In years lost birthday) 81 years	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10B. KIND OF BUSINESS OR INDUSTRY Sister of Charity		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Walter Lindley		14. MOTHER'S MAIDEN NAME Isabel Hartley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-0688-J1		17. INFORMANT Sister Andrea	
				ADDRESS same address	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CORONARY OCCLUSION 1 day		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CORONARY OCCLUSION (B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROSIS 6 years (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 6 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED None		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May, 1963 to December 1969, that (I) (we) last saw the deceased alive on December 2, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Damian P. Alagia, M.D.		23B. DATE SIGNED December 4, 1969			
23C. PHYSICIAN'S NAME (Type) Damian P. Alagia, M.D.		23D. ADDRESS 3326 Frederick Ave., Baltimore, Md. 21228			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/6/69		24C. NAME OF CEMETERY OR CREMATORY Villa St. Michael on grounds Seton Inst. 6400 Wabash Av.	
24D. LOCATION (City, town, or county) (State) Baltimore City		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR STEWART S. MOVEN		25D. ADDRESS 108 W. North Av., Cityl			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12168</u>	
F-326 69 12168		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Sister Agnes Fitzsimmons		December 7, 1969		8:30 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 94 Villa St. Michael		A. STATE		B. COUNTY	
		Maryland		Baltimore City	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		4000 Forest Hill Road			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
F.	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2-25-1886	83	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Pharmacist		Sister of Charity		Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
James J. Fitzsimmons		Bridget Flaherty		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		219-54-0231-JL		Sister Andrea, 4000 Forest Hill Road	
18. <u>440.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Cardiovascular Collapse DUE TO, OR AS A CONSEQUENCE OF:			2 days
		(B) Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF:			15 years
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None		None		None	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
None		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		None	
22. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>54</u> to <u>December</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
				December 7, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Damian P. Alagia, M. D.				3326 Frederick Avenue, 21228	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12/9/69		Villa St. Michael - on grounds of Seton Inst.-6400 Wabash	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 10 1969		J. E. S. JONES		SEWART & S. OWEN CO. 108 W. North Ave. Cityl	



69 12169

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12169

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

Lucille Miles

2. DATE

Known ☒ Estimated ☐

Month

Day

Year

Hour

OF DEATH

Estimated ☐

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

3. DATE PRONOUNCED DEAD

Month

Day

Year

Hour

12

8

69

5:15 p.

M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Howard

6300

6. SEX

female

7. RACE

SOI

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Jessup

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

9-18-1915

10. AGE (In years last birthday)

54

If Under 1 Yr. II Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

Box 279, Washington Blvd.

11. BIRTHPLACE (State or foreign country)

CHARLES CITY VA

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

ROBERT A. CHARITY JR.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

MAID

14B. KIND OF BUSINESS OR INDUSTRY

RETAIL FURNITURE

15. MOTHER'S MAIDEN NAME

Mrs. SUSIE MILES

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

NO

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

CARRIE C. CHARITY - Jessup MD

19.

E 814.7

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Multiple injuries DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or above home, farm, factory, street, office bldg., etc.)

street

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

U.S. Rt. 1 near Lincoln Dr. - Jessup, Md.

22D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

12 8 69 4:50 pm

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

pedestrian struck by car

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinionresulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Deputy Chief Medical Examiner

12/9/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Removal

24B. DATE

12/10/69

24C. NAME OF CEMETERY or CREMATORY

GUILDFIELD BRT.

24D. LOCATION (City, town, or county)

CHARLES CITY CO. VA

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 10 1969

25B. NAME OF REGISTRAR

Robert E. Spitz

25C. FUNERAL DIRECTOR

Marshall D. Spitz

ADDRESS

6300 GILMAN

0151 00

RECEIVED BY AIR MAIL 12/15/50

RECEIVED BY AIR MAIL 12/15/50

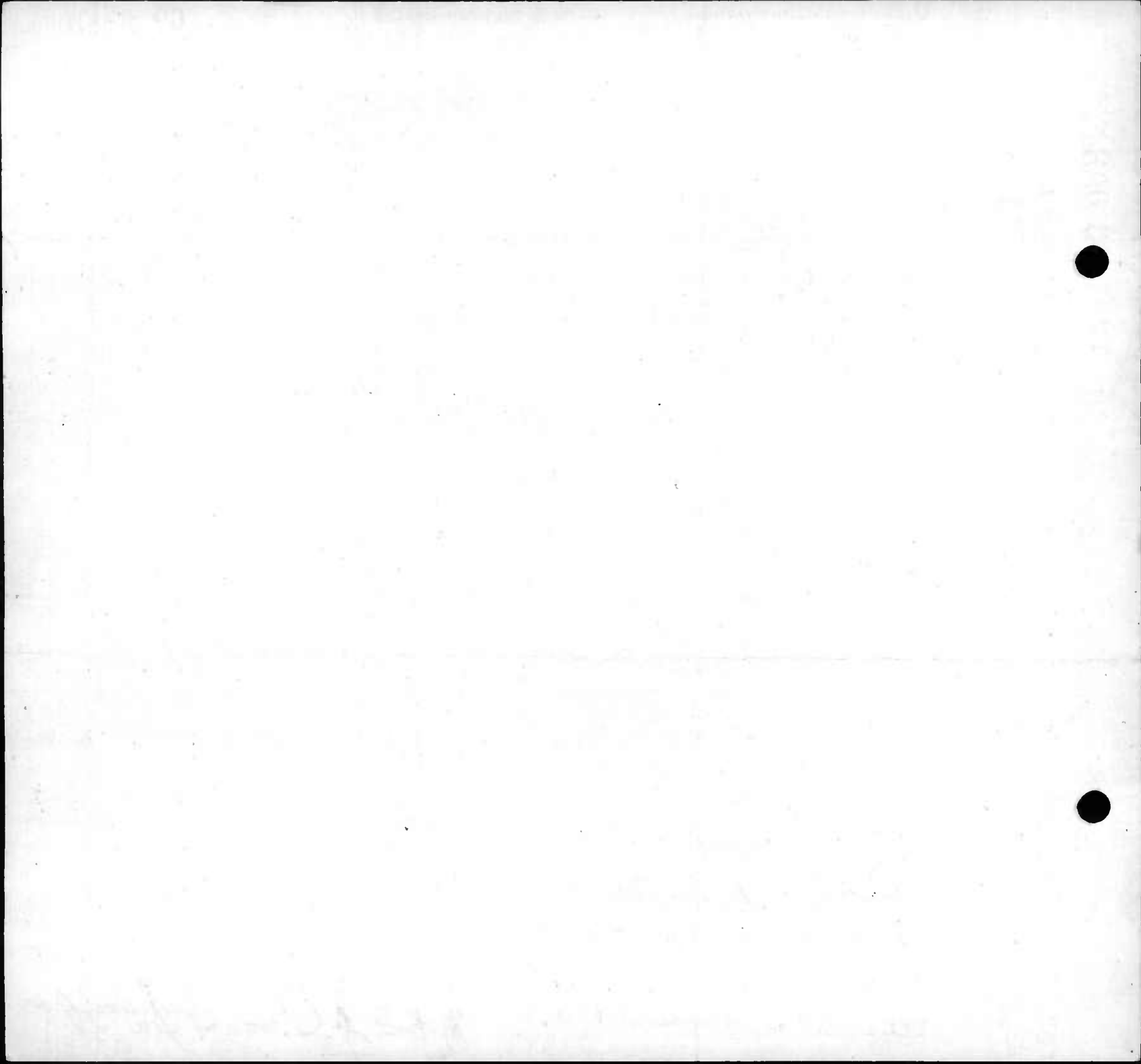
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

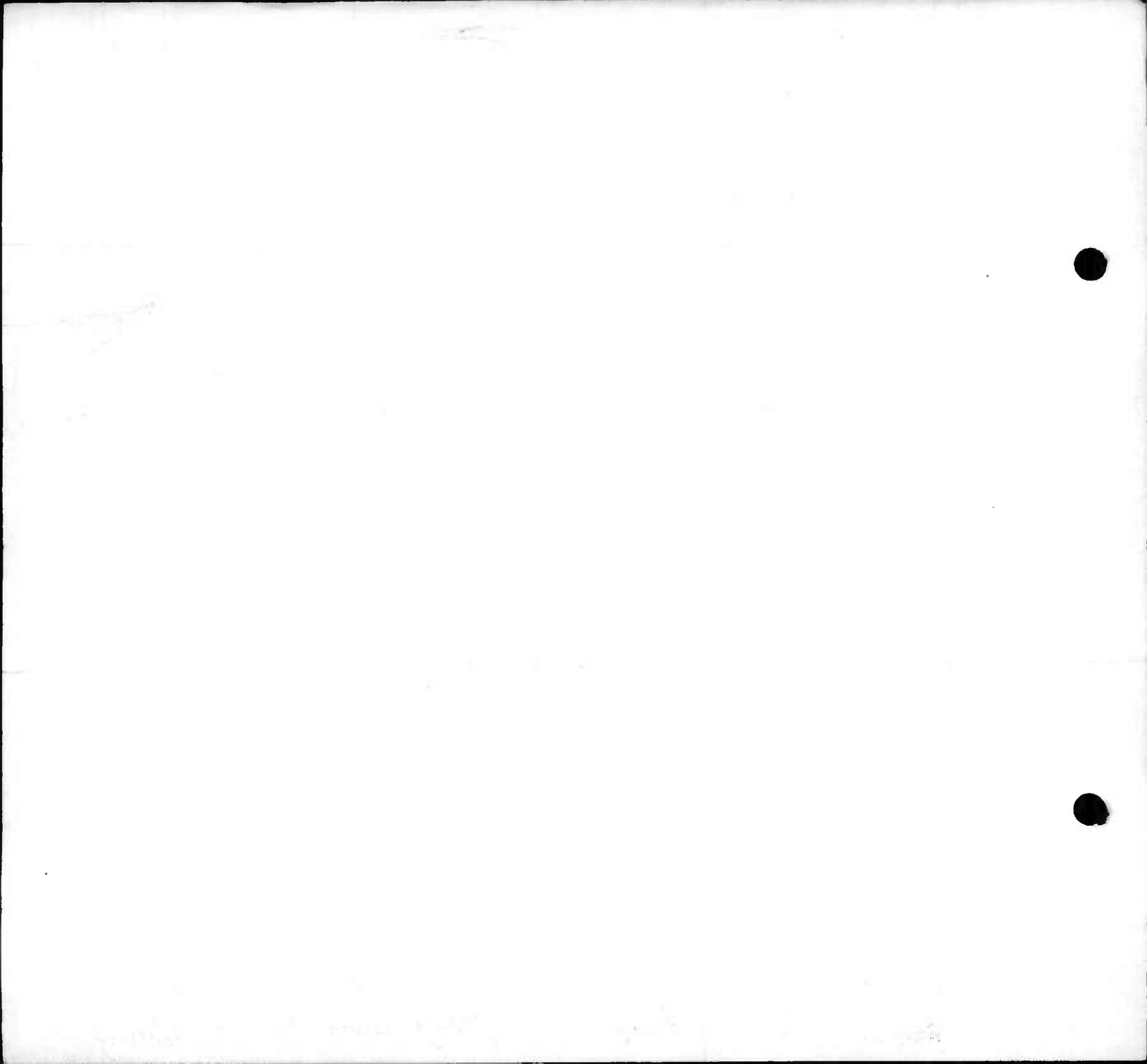
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12170	
W-524		69 12170		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Dominikas, Wenslavas		2. DATE AND HOUR OF DEATH 12/9/69 6:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 49 North Charles Gen. Hospital (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1803			
5. SEX MALE		6. RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garbo		10B. KIND OF BUSINESS OR INDUSTRY Clothing Co.		8. DATE OF BIRTH 1/2/95	
13. FATHER'S NAME PETER WENSLAUS		14. MOTHER'S MAIDEN NAME ROSE ?		9. AGE (In years last birthday) 74	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-10-5599A		11. BIRTHPLACE (State or foreign country) Lithuania	
17. INFORMANT Algirdas Rimkevicius		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
18. 162.1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA of THE LUNG		(?)	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/28 19 69 to 12/9 19 69 , that (I) (we) last saw the deceased alive on 12/9 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Danilo V. Santos M.D.		23B. DATE SIGNED 12/9/69		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) DANILO V. SANTOS M.D.		23D. ADDRESS NORTH CHARLES GEN HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/69		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969			
25B. NAME OF REGISTRAR Robert E. Talbot, Jr.		25C. FUNERAL DIRECTOR John J. Cowan			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

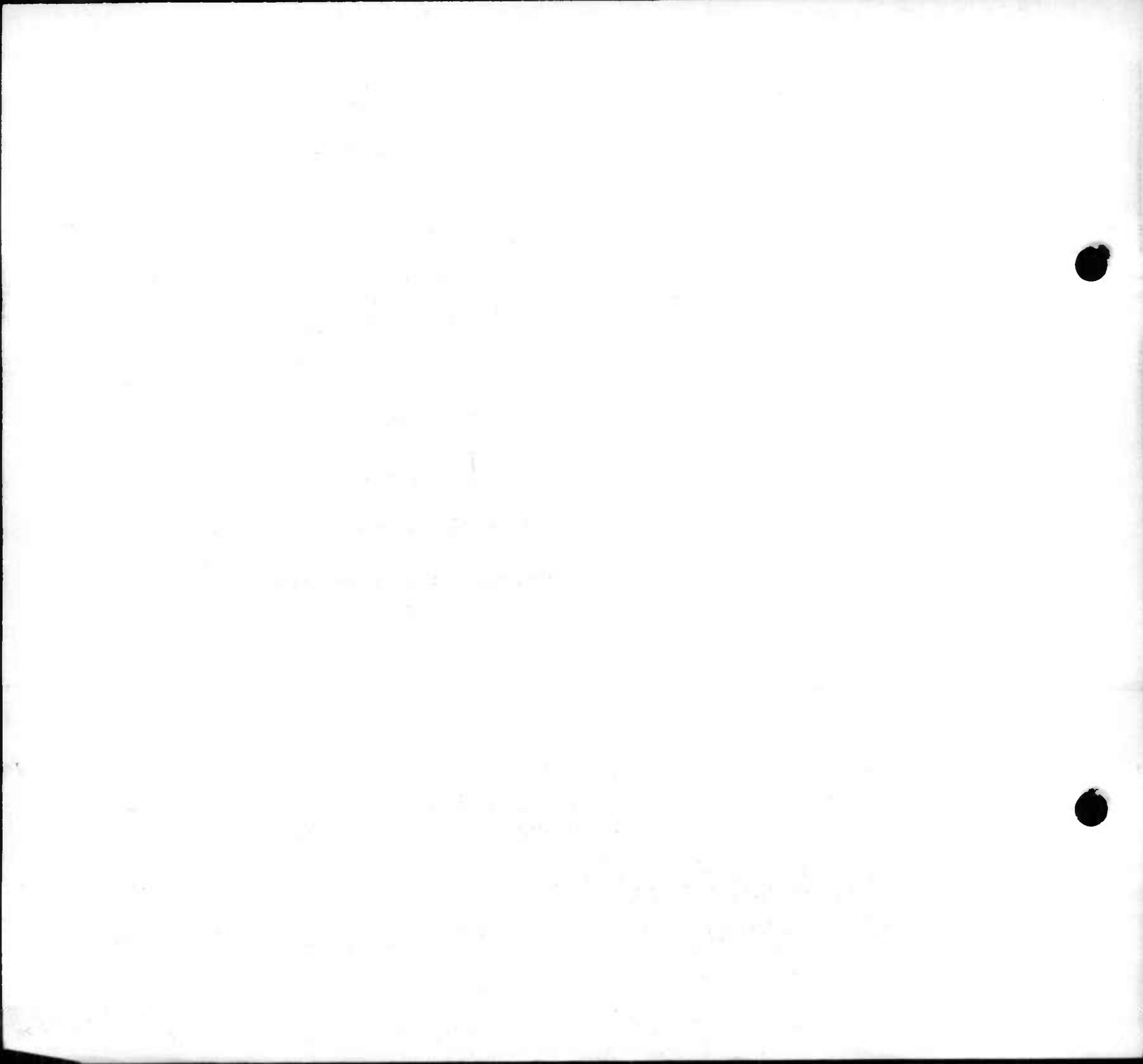
W-324		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12171	
69 12171		CERTIFICATE OF DEATH		69 12171	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MRS. MARY WEITZEL</u>		2. DATE AND HOUR OF DEATH <u>12-6-69</u> <u>10:40 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>001</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME HOSPITAL</u> <u>35</u>		E. STREET AND NUMBER <u>20 N. EAST AVE.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-24-07</u>	9. AGE (in years last birthday) <u>62</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (State or foreign country) <u>EUROPE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>		13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>21-24-8357</u>		17. INFORMANT <u>WALTER WISS</u> ADDRESS <u>20 N. EAST AVE.</u>	
18. <u>25091</u> CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIO RESPIRAT. FAIL.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>DIABETES. CH. AT. FIBRILLATION</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>YEARS</u>	
(C) _____					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11-19-69</u> <u>19 69</u> to <u>12-6</u> <u>19 69</u> and that (I) (we) last saw the deceased alive on <u>12-6</u> <u>19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>C. Vergara, M.D.</u>		23B. DATE SIGNED <u>12-6-69</u>		23C. PHYSICIAN'S NAME (Type) <u>CORAZON Z. VERGARA, M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-10-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy REDEEMER</u>	
24D. LOCATION <u>BALTIMORE, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>John J. Conner</u>		25D. ADDRESS <u>25 N. Hollis St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12172	
C-635 69 12172		69 12172	
BIRTH NO. 69 12172		BIRTH NO. 69 12172	
1. NAME OF DECEASED (Type or Print) VICTORY ANN CURTAIN		2. DATE AND HOUR OF DEATH 12-5-69 4:40 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 34 BON SECOURS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1903 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1725 HOLLINS STREET	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-3-69
9. AGE (In years last birthday) 1		10. Under 1 Yr. Months: Days: 1	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) BALTIMORE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JAMES RICHARD CURTAIN		14. MOTHER'S MAIDEN NAME PAULINE BALLARD	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MOTHER		ADDRESS	
18. 726.21 CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE Immature. DUE TO, OR AS A CONSEQUENCE OF: 6 month Gestation; 1-20g. (B) DUE TO, OR AS A CONSEQUENCE OF: Respiratory failure (C)	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased, from 12-3-69 19 to 12-5-69 19 that (X) (we) last saw the deceased alive on 12-4-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Khalid Qureshi MD		23B. DATE SIGNED 12-5-69	
23C. PHYSICIAN'S NAME (Type) DR QURESHI MD		23D. ADDRESS BON-SECOURS-HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 12/8/69	24C. NAME OF CEMETERY OR CREMATORY ST Peter's	24D. LOCATION (City, town, or county) (State) Pecks Md
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969	25B. NAME OF REGISTRAR John E. Fisher, M.D.	25C. FUNERAL DIRECTOR TA & J Kennedy/NC Pecks	ADDRESS



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N-240

69 12173

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12173

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) CHARLES MILTON NAGEL (CHARLES NAGAL-NAGEL)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 6, 1969		Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year December 6, 1969		Hour 11:34 P.M.
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2605				
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH Aug. 23, 1915		10. AGE (In years last birthday) 54	E. STREET AND NUMBER 315 S. Cornwall Street # 21224.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John F. Nagel, Sr.
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		14B. KIND OF BUSINESS OR INDUSTRY Self		15. MOTHER'S MAIDEN NAME Nora A. Bozman
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W.II		17. SOCIAL SECURITY NO. 217-09-8644		18. INFORMANT Mildred D. Nagel: ADDRESS Same.
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 7, 1969				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-69		24C. NAME of CEMETERY or CREMATORY Sacred Heart Cemetery
24D. LOCATION (City, town, or county) (State) 7401 German Hill Rd., Ba. Co., Md.				
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Charles S. Feiler ADDRESS 901 S. Conkling St. Balto., 21224, Md.

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FUNERAL DIRECTOR: IMPORTANT

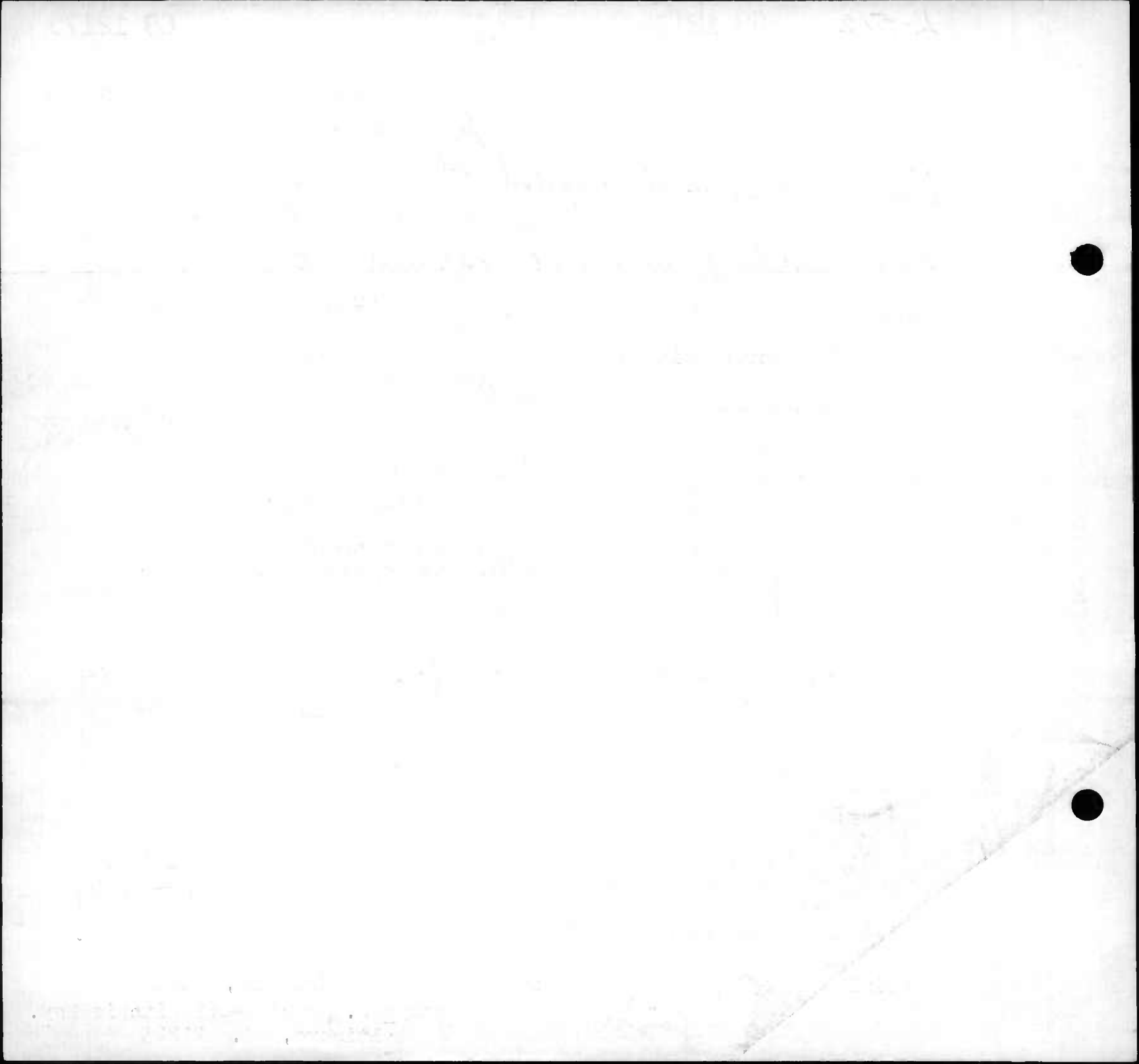
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-240		69 12174		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12174	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) LEVI C. LOECHEL				2. DATE AND HOUR OF DEATH 12-3-69 9:55 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY OF MD. HOSPITAL 38				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PA. B. COUNTY V-35			
5. SEX M 6. RACE CAUC. 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9-30-10		9. AGE (In years last birthday) 59	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIREMAN				10B. KIND OF BUSINESS OR INDUSTRY RAILROAD		11. BIRTHPLACE (State or foreign country) MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME CLARENCE LOECHEL			
14. MOTHER'S MAIDEN NAME OLLIE GNAGEY				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 219-14-7199				17. INFORMANT MRS. MARGARET LOECHEL-GARRETT			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH VENTRICULAR FIBRILLATION (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ARTERIOSCLEROTIC HEART DISEASE WITH MYOCARDIAL INFARCTION				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from DEC 3RD 1969 to DEC 3RD 1969 that (I) (we) last saw the deceased alive on DEC 3RD 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Gilbert M. Carouge M.D.				23B. DATE SIGNED 12-3-69		23C. PHYSICIAN'S NAME (Type) GILBERT M. CAROUGE, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 12/6/69		24C. NAME OF CEMETERY OR CREMATORY GRANTSVILLE CEMETERY	
24D. LOCATION (City, town, or county) (State) GRANTSVILLE GARRETT, MD.				25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969			
25B. NAME OF REGISTRAR Robert E. Fisher, R.D.				25C. FUNERAL DIRECTOR Ruth Plummer			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

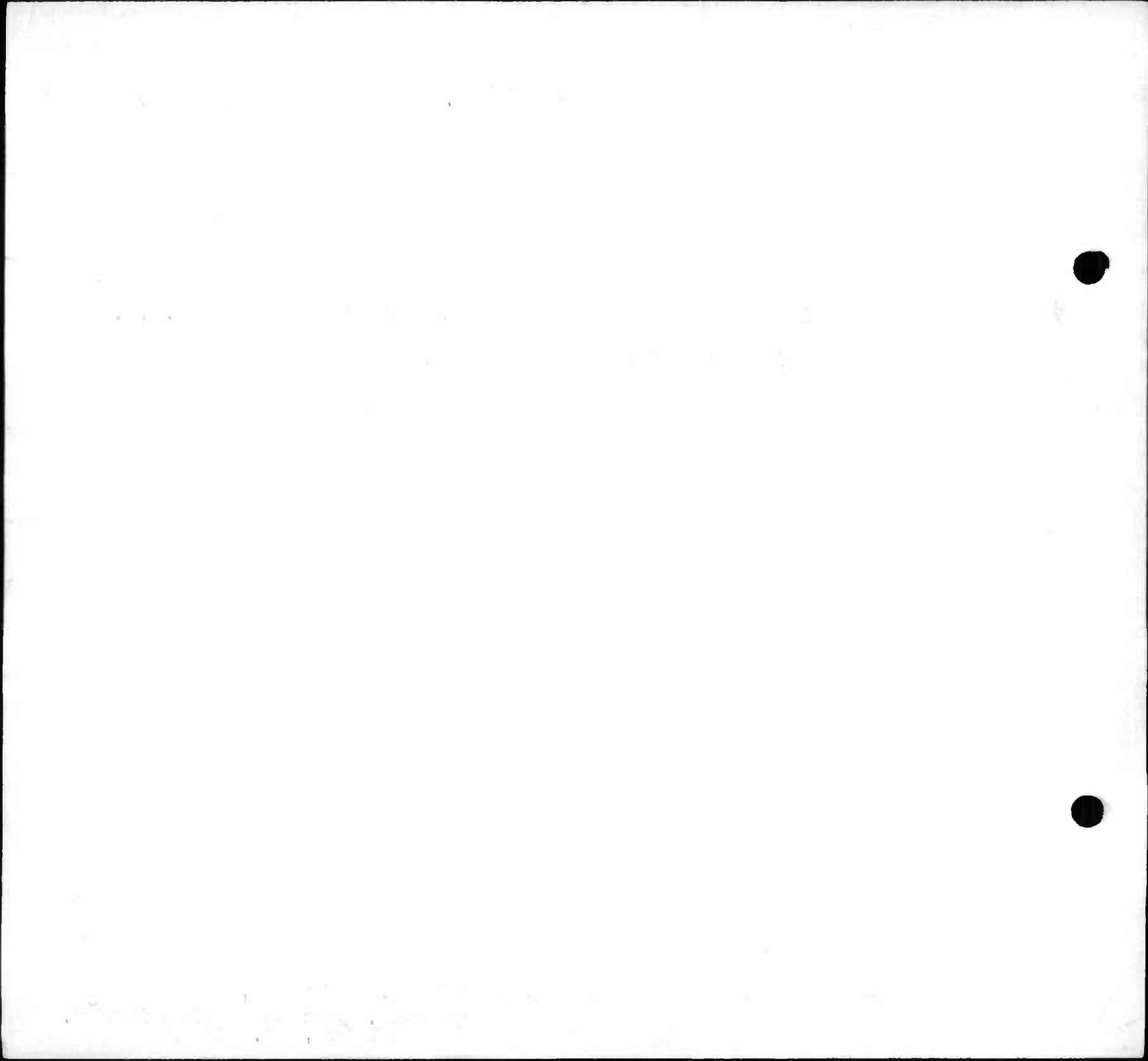
L-512 69 12175		BALTIMORE CITY HEALTH DEPARTMENT		X		Registered No. 69 12175	
CERTIFICATE OF DEATH							
BIRTH NO.		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				Vernon Leimbach		12/7/69 4 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 Maryland General Hospital				A. STATE B. COUNTY Maryland Anne Arundel 5200			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Riviera Beach			
D. STREET ADDRESS (If rural, give location) 8455 Garden Road							
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
Male	White	Widowed	06/29/12	57			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Leader		Beth. Steel		B Maryland		U.S.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
P George Leimbach				P Dora			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO 2150132		215013243		Dolores Caldwell daughter		21225 3828 Headenhall St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Cerebral Hypoxia & Edema					
ANTECEDENT CAUSES		(A) DUE TO					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		POST-OPERATIVE CARDIAC ARREST					
		(B) DUE TO					
		MASSIVE RETROPERITONEAL					
		(C) HEMORRHAGE, SOURCE UNDETERMINED					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
11/11/69		RETROPERIT. HEMORRHAGE		YES		YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
NO							
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
M.L.S. Brown						12/8/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
M.L.S. Brown							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/11/69		Holy Cross		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 10 1969		Robert E. Taylor, M.D.		George J. Gonce		4001 Ritchie Hgy. Baltimore, Md. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

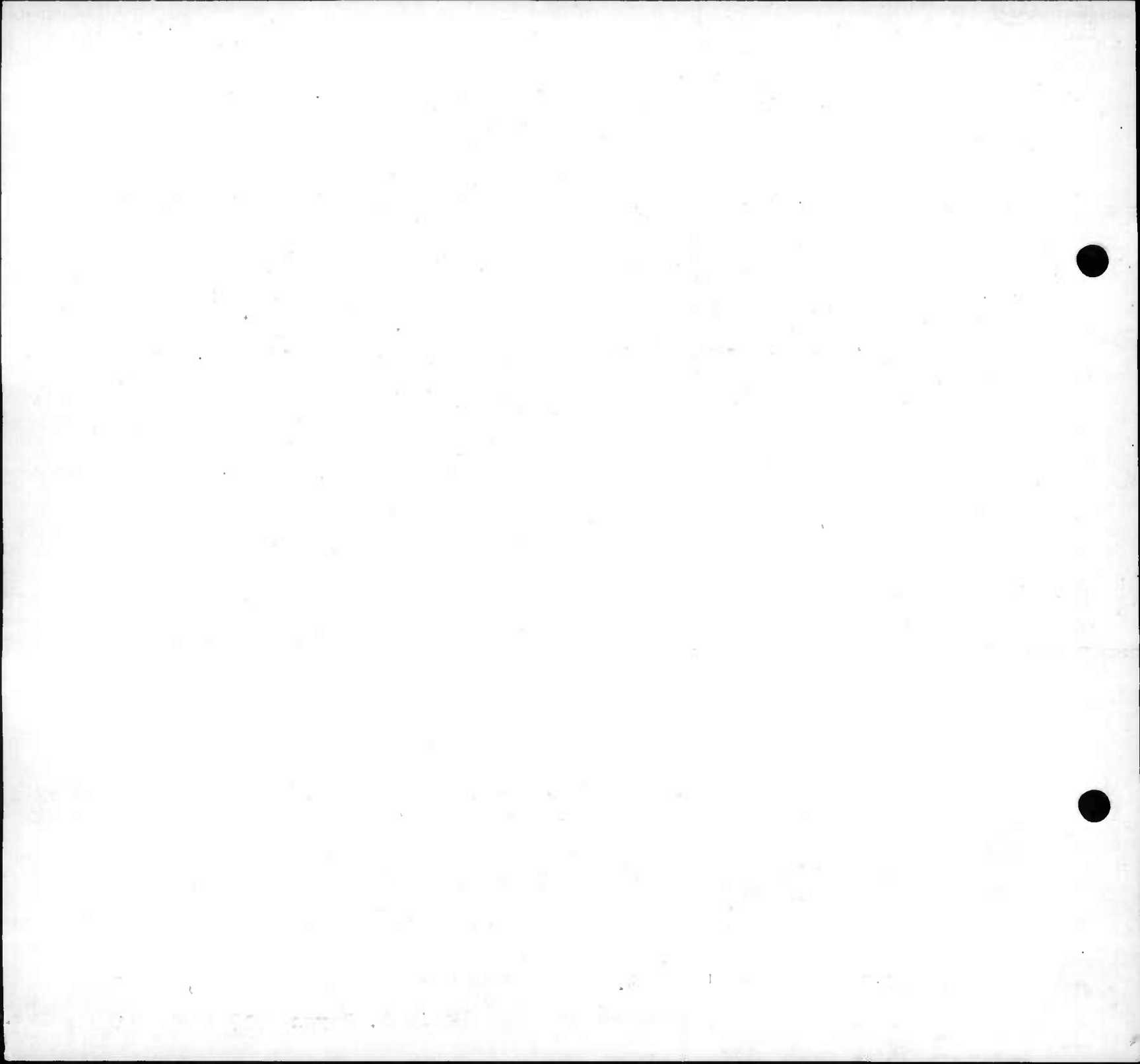
5-332		69 12176		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12176	
CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <u>STATCHUK, LORETTA</u>					2. DATE AND HOUR OF DEATH <u>6 Dec 1969</u> <u>7:15 P.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>South Baltimore General Hosp.</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2544</u>				
					C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER <u>933 Heunow Court</u>				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-26-21</u>	9. AGE (In years last birthday) <u>48 yrs.</u>	10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Bismarck Holtz</u>					14. MOTHER'S MAIDEN NAME <u>Stella Elizabeth Allen</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-14-0093</u>		17. INFORMANT <u>Mrs. Stella Autodone</u>			
				ADDRESS					
18. <u>410.9 I</u> CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)									
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
(A) IMMEDIATE CAUSE <u>Myocardial Infarction,</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Acute</u>									
(B) _____ DUE TO, OR AS A CONSEQUENCE OF: _____									
(C) _____ DUE TO, OR AS A CONSEQUENCE OF: _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>12-6-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Specify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-6-69</u> to <u>12-6-69</u> and that (I) (we) last saw the deceased alive on <u>12-6-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Virginia V. Fausto, M.D.</u>					23B. DATE SIGNED <u>12-6-69</u>			23C. PHYSICIAN'S NAME (Type) <u>VIRGINIA V. FAUSTO, M.D.</u>	
					23D. ADDRESS <u>South Balto. General Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12/9/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial Pk.</u>		24D. LOCATION (City, town, or county) (State) <u>Elkridge, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Baker, M.D.</u>		25C. FUNERAL DIRECTOR <u>George O. Conce</u>		25D. ADDRESS <u>4001 Ritchie H y. Baltimore, Md. 21225</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

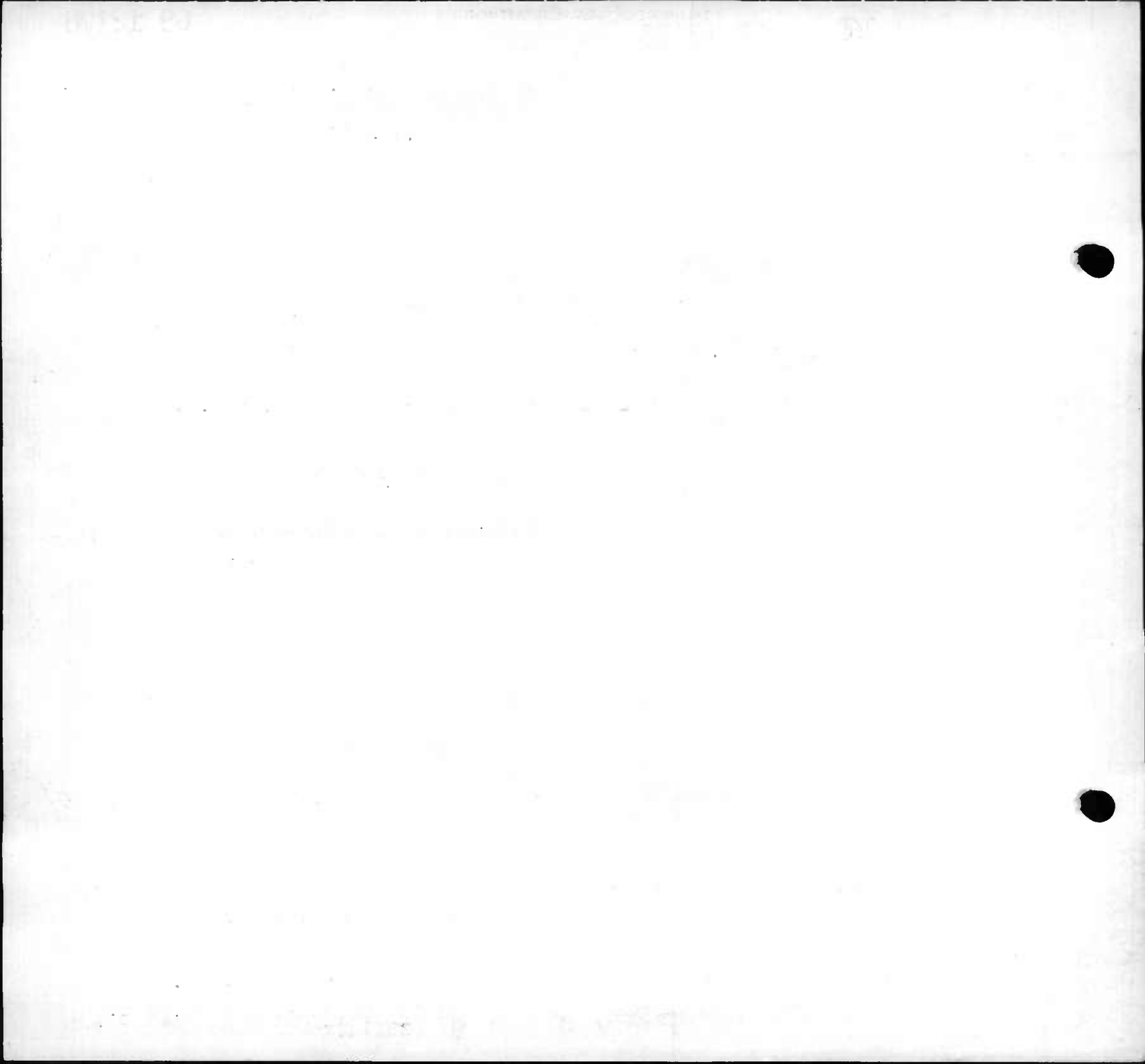
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12177
P-620		69 12177		BIRTH NO.
1. NAME OF DECEASED (Type or Print) PRICE - WILLAM		2. DATE AND HOUR OF DEATH Dec. 5-1969 @ 2:55 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Bolton Hill Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2755		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bolton Hill Nursing Home		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male		6. RACE negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not known RETIRED		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH 6/26/83
13. FATHER'S NAME Alfred Price		14. MOTHER'S MAIDEN NAME Eliza Madden		9. AGE (In years last birthday) 86
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-10-3055		11. BIRTHPLACE (State or foreign country) SPARKS Md.
17. INFORMANT Bolton Hill Nursing Home - Baltimore Md.		12. CITIZEN OF WHAT COUNTRY? USA		
18. 157.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Carcinoma pancrea		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several weeks		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Chronic Brain Syndrome				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12-2-1967 to 12-5-1969 , that (I) (we) last saw the deceased alive on 12-4-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE E. Ellsworth Cook M.D.				23B. DATE SIGNED 12-6-69
23C. PHYSICIAN'S NAME (Type) E. Ellsworth Cook		23D. ADDRESS 2431 Maryland Ave. Balto. Md.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 9 '69		24C. NAME OF CEMETERY or CREMATORY St. Thomas Cemetery
24D. LOCATION (City, town, or county) (State) Randallstown, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		
25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR Lewis T. Gwynn		
		ADDRESS 4517 Park Heights Ave.		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

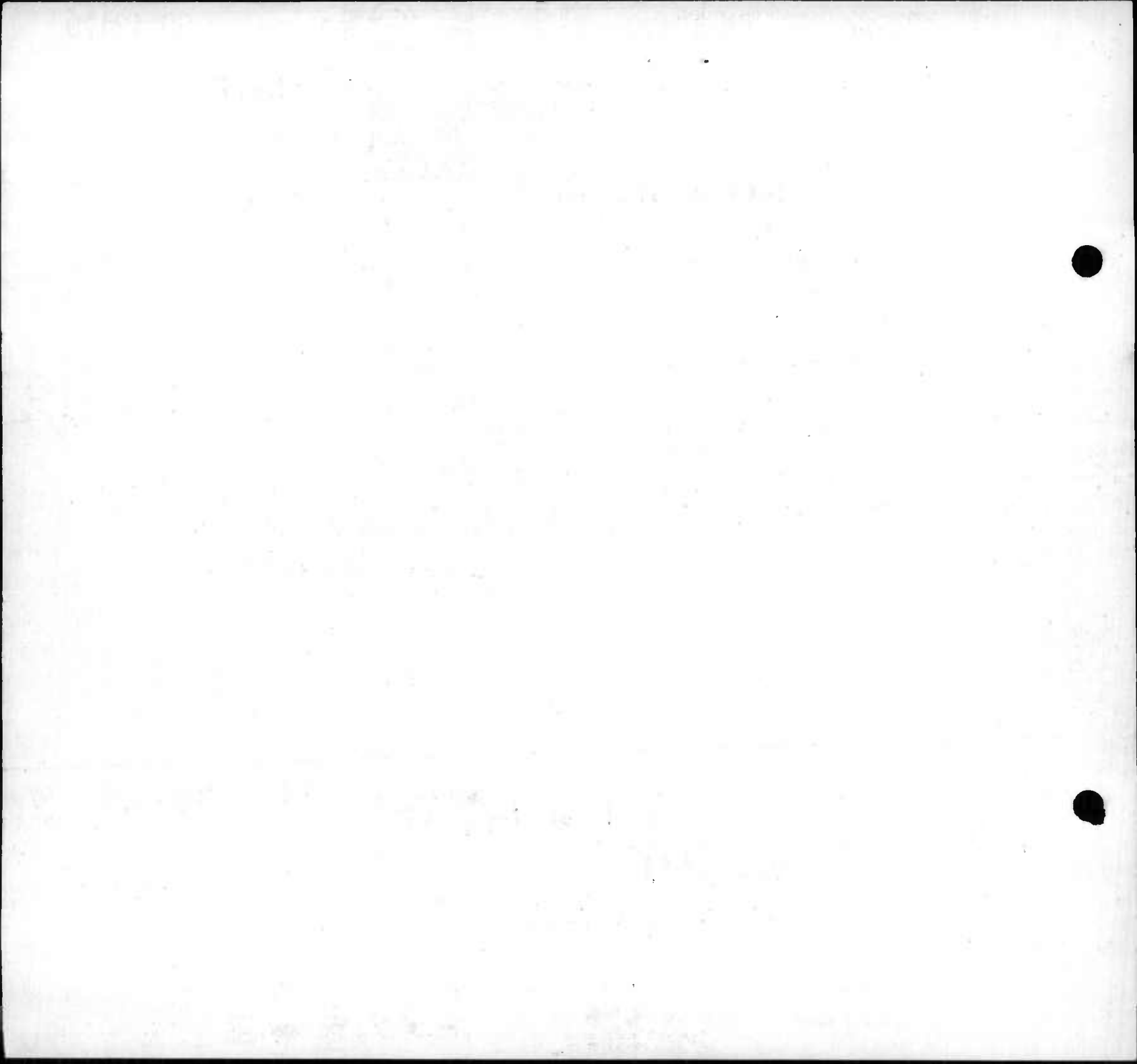
<div style="display: flex; justify-content: space-between;"> 420 69 12178 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 69 12178 </div>	
BIRTH NO. 1 1. NAME OF DECEASED (Type or Print) ANNA CATHERINE DE LUCA	
2. DATE AND HOUR OF DEATH Dec. 6, 1969 10:10 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 3509 Dudley Avenue	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md., 21213 B. COUNTY 2643 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3509 Dudley Avenue	
5. SEX female 6. RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/3/87 9. AGE (In years last birthday) 82 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY at home 11. BIRTHPLACE (State or foreign country) Baltimore, Md. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Conrad H. Foose 14. MOTHER'S MAIDEN NAME Mary Keller	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 212-07-3895 17. INFORMANT Anastasia Miller, dght. above ADDRESS	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from June 1946 to Dec 6 1969 , that (I) (we) last saw the deceased alive on Dec 3 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE William L. Fearing 23B. DATE SIGNED 12-9-69 23C. PHYSICIAN'S NAME (Type) Dr. William L. Fearing 23D. ADDRESS 3025 Belair Road 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12/9/69 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park 24D. LOCATION (City, town, or county) (State) Baltimore, Md. 25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969 25B. NAME OF REGISTRAR John E. Fearing 25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. ADDRESS 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-160		69 12179		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 12179	
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) RANDOLPH Benjamin R Cooper						2. DATE AND HOUR OF DEATH 1 a m 12/4/69					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Wicomico					
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital						C. CITY OR TOWN Salisbury			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 403 Dover St.											
5. SEX M		6. RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-8-22		9. AGE (In years last birthday) 47		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman				10B. KIND OF BUSINESS OR INDUSTRY Automobile		11. BIRTHPLACE (State or foreign country) Delaware			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Benjamin Clyde Cooper						14. MOTHER'S MAIDEN NAME Julia Eleanor Owens					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-26-4095		17. INFORMANT Annette Cooper (wife)			ADDRESS same as above		
18. 382X I CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: hemie					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) Chronic renal failure DUE TO, OR AS A CONSEQUENCE OF: hypertension					
(C) _____											
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 2/12/2 19 69 to 12/4 19 69 , that (I) (we) last saw the deceased alive on 1 a m 12/4 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Praima Khastagir MD								23B. DATE SIGNED 12/4/69			
23C. PHYSICIAN'S NAME (Type) PRAIMA KHASTAGIR								23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/6/69		24C. NAME OF CEMETERY or CREMATORY Wicomico Memorial Park				24D. LOCATION (City, town, or county) (State) Salisbury, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969				25B. NAME OF REGISTRAR Robert E. Taylor				25C. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460		69 12180		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12180	
BIRTH NO. [REDACTED]				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) Mabelle Tyler Mabelle M. Tyler				12/6/69 10:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Baltimore General Hospital 3001 S. Hanover St.				A. STATE Md.		B. COUNTY Baltimore City	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 935 Lemon St.							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/12/1900	9. AGE (In years lost birthday) 69 (7)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Lady				10B. KIND OF BUSINESS OR INDUSTRY RiverDine Store		11. BIRTHPLACE (State or foreign country) N. Carolina	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME H. T. Stallings				14. MOTHER'S MAIDEN NAME Fannie?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 21354-0318		17. INFORMANT Mr. Kenneth Callahan	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1830 I Severe debility & anemia				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. advanced ca. - lung probably Ovary with metastases - minimal				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/26/1969 to 12/5/1969 that (I) (we) last saw the deceased alive on 12/5/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 12/6/69			
23C. PHYSICIAN'S NAME (Type) DR. CECILIA CHEN.				23D. ADDRESS 3001 S. Hanover St. Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/69		24C. NAME OF CEMETERY or CREMATORY Glen Haven		24D. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR John J. Cowan & Son.		ADDRESS 901 Hollins St.	

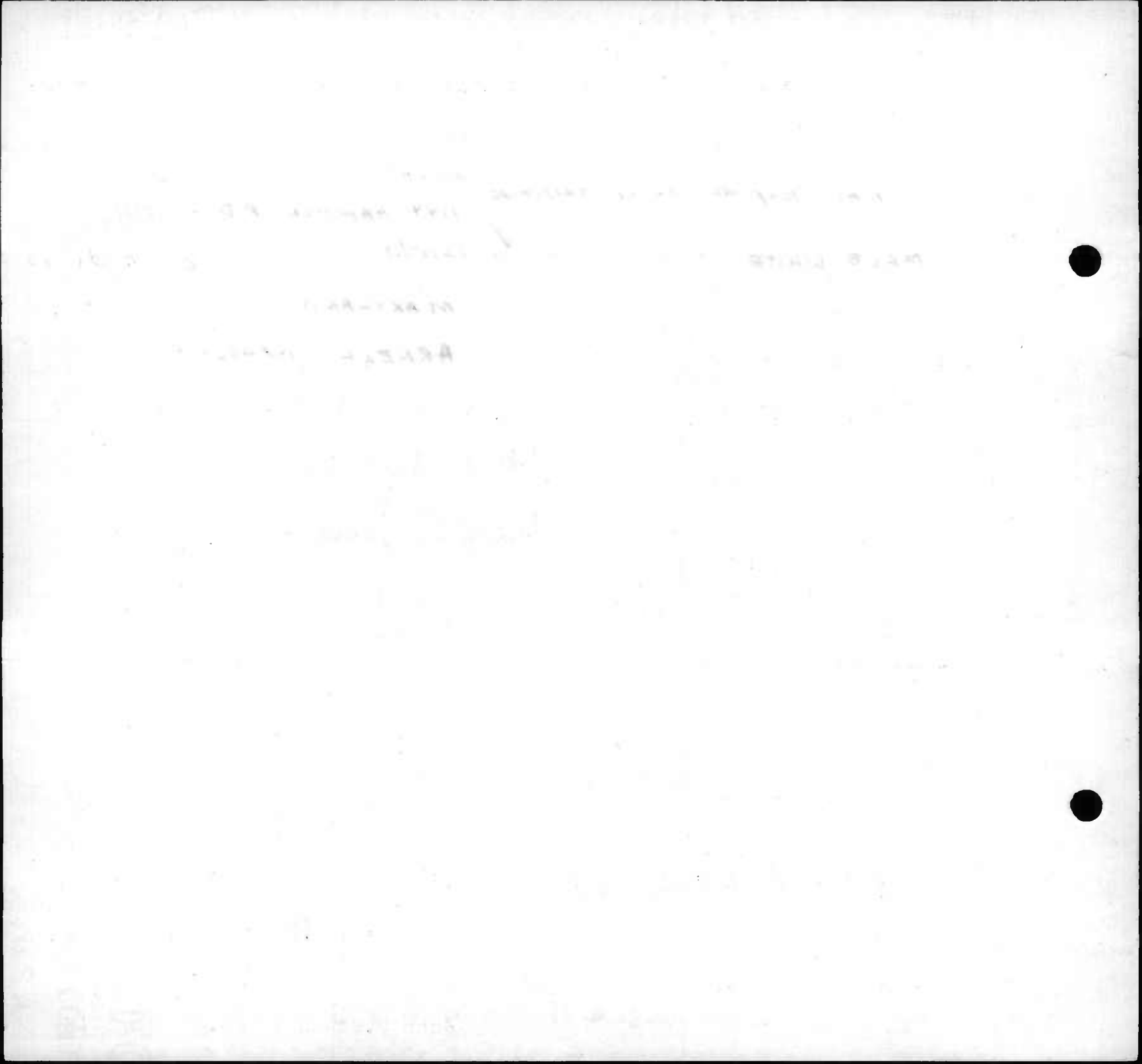
lemmon st.

[REDACTED]

FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12181	
T-124 69 12181 69-23313		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) (BABY BOY) TABAK, ARNELL		2. DATE AND HOUR OF DEATH 12/5/69 7:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 SINAI HOSPITAL INC OF BALTIMORE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY AA C. CITY OR TOWN ANNAPOLIS D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1144 HAMPTON RD - Rt 4	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/68
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby		10B. KIND OF BUSINESS OR INDUSTRY None	9. AGE (In years last birthday) 0 0 8 10
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Tabak		14. MOTHER'S MAIDEN NAME ARNELL BRADLEY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Geo. Tabak - Rt 4 1144 Hampton Rd.		ADDRESS	
18. 769.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Immunization ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. Cerebral incompetence		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Cerebral incompetence (C) —	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) 0		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 19 to 19 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Samuel Rubin MD		23B. DATE SIGNED 12/5/69	
23C. PHYSICIAN'S NAME (Type) Samuel Rubin MD		23D. ADDRESS 5915 Park Heights Ave	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/9/69	
24C. NAME OF CEMETERY OR CREMATORY Trinity Olivet Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR John J. Cowan	
25C. FUNERAL DIRECTOR John J. Cowan		ADDRESS Son. 901 Hollins St	



M-300

69 12182

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12182

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Ethel R. Mattee

2. DATE
OF
DEATHKnown ☐ Month Day Year Hour
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

St. Agnes Hospital (DOA)

3. DATE
PRONOUNCED DEADMonth Day Year Hour
12 7 1969 7 P. M.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE Md. B. COUNTY Baltimore Co. 5300

6. SEX

Female

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

7-27-1895

10. AGE (In years
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

106 Shady Nook Ave.

11. BIRTHPLACE (State or foreign country)

Penna.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Carl Rudolph

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Clerk

14B. KIND OF BUSINESS OR INDUSTRY

Laundry Company

15. MOTHER'S MAIDEN NAME

Emma Wertz

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL
SECURITY NO.

215-012594

18. INFORMANT

Benjamin L. Mattee 106 Shady Nook Ct.

ADDRESS

21228

19.

412.4

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-8-69

24A. BURIAL CREMATION,
REMOVAL (Specify)

12-10-1969

24B. DATE

Burial

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION (City, town, or county) (State)

Frederick Rd. Balto. Md

25A. DATE REC'D BY HEALTH DEPT.

DEC 10 1969

25B. NAME OF REGISTRAR

Russell S. Fisher, M.D.

25C. FUNERAL DIRECTOR

301 Frederick Rd.

ADDRESS 21228

CRISTO

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-634		69 12183		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12183	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>SURDEL Anna</i>				2. DATE AND HOUR OF DEATH <i>12/4/69 6:15 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>34 Bon Secours Hosp.</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>101</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>3028 Elliott Street</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>02/14/02</i>	9. AGE (In years last birthday) <i>67</i>	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Samuel Czycia</i>				14. MOTHER'S MAIDEN NAME <i>Josephine</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service				16. SOCIAL SECURITY NO. <i>217-03-8631</i>		17. INFORMANT ADDRESS	
18. <i>250.9 14 195.0</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>PNEUMONIA</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>DIABETES MELLITIS</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>ABDOMINAL MALIGNANCY</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>EARLY CONGESTIVE HEART FAILURE</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <i>11-23-69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ASCITES</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>11-15-69</i> to <i>12-4-69</i> and that (1) (the) last saw the deceased alive on <i>12-4-69</i> and that (in my) (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>John C. Kerr M.D.</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>12-4-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>JOHN C. KERR M.D.</i>				23D. ADDRESS <i>BON SECOURS HOSPITAL BAKTO #23</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-9-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Rosary Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE RECEIVED BY HEALTH DEPT. <i>DEC 10 1969</i>		25B. NAME OF REGISTRAR <i>WALTER DABROWSKI</i>		25C. FUNERAL DIRECTOR ADDRESS <i>1005 DUNDALK AVENUE</i>			

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K-250

69 12184 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12184

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN P. KUSMA

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour
December 6, 1969 M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospital (DOA)

3. DATE PRONOUNCED DEAD Month Day Year Hour
December 6, 1969 6:25 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

2636

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

Aug 9 1907

10. AGE (In years last birthday)

62

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

6724 Duluth Avenue

11. BIRTHPLACE (State or foreign country)

Wilkes Barre Pa

12. CITIZEN OF WHAT COUNTRY?

John Kusma

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

U S Army

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Mrs Lillian Kusma 6724 Duluth Avenue

19.

412.41

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

December 7, 1969

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-10-69

24C. NAME of CEMETERY or CREMATORY

Holy Rosary Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 10 1969

Robert E. Taylor, M.D.

WALTER DABROWSKI 1005 DUNDALK AVENUE

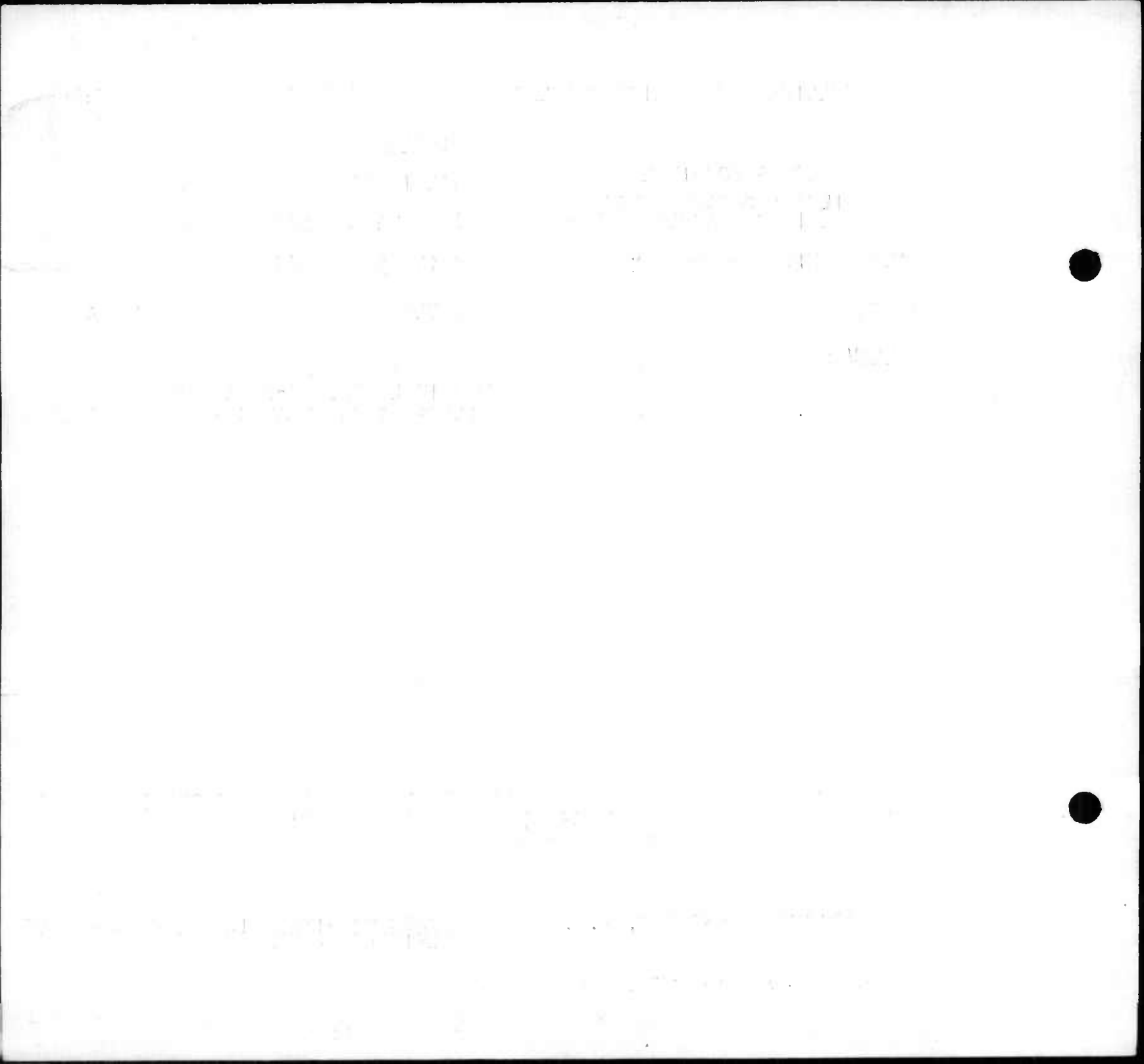
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-415		69 12185		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12185	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) SULLIVAN, FREDERICK CHARLES				2. DATE AND HOUR OF DEATH DECEMBER 07, 1969 5:30P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST AGNES HOSPITAL WICKENS & CATON AVES BALTIMORE MARYLAND 21229				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2553			
5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 02 14 03		9. AGE (In years last birthday) 66	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN				10B. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME SULLIVAN, Howard			
14. MOTHER'S MAIDEN NAME Berthaet, Regina				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No			
16. SOCIAL SECURITY NO. 214-01-1034				17. INFORMANT HOSPITAL RECORDS-ST AGNES WILKENS & CATON AVES BALTO MD 21229			
I				CAUSE OF DEATH			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE Coronary vascular collapse DUE TO, OR AS A CONSEQUENCE OF: renal shut down			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) Ca of stomach metastasis			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Infully medical examined <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from DECEMBER 1 19 69 to DECEMBER 7 19 69 that (H) (we) last saw the deceased alive on DECEMBER 7 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Pricha Boonswang M.D.				23B. DATE SIGNED 12/7/69		23C. PHYSICIAN'S NAME (Type) PRICHA BOONSWANG, M.D.	
23D. ADDRESS ST AGNES HOSPITAL WILKENS & CATON AVE BALTIMORE MARYLAND 21229				23E. NAME OF CEMETERY or CREMATORY St. Olmest Cemetery		23F. LOCATION (City, town, or county) (State) Balt. Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/69		24C. NAME OF REGISTRAR Robert E. Taylor, R.D.		24D. FUNERAL DIRECTOR John J. Edwards, Inc. 901 Hollins St.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-514		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12186	
69 12186		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>GEORGE LEE CAMPBELL</u>		2. DATE AND HOUR OF DEATH <u>12.6.69</u> <u>11.40 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>35</u> <u>CHURCH HOME AND HOSPITAL</u> <u>BALTIMORE MD 21231</u>		C. CITY OR TOWN <u>Middle River</u> <u>Baltimore</u>		D. INSIDE CITY LIMITS? <u>YES</u> <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>318 Bourque Avenue</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-9-08</u>	9. AGE (In years lost birthday) <u>61</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Security Guard</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Printer</u>		11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICA</u>		13. FATHER'S NAME <u>Thomas Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth HART</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>238-09-0077</u>		17. INFORMANT <u>Dr Prabir K. Bose</u> ADDRESS <u>Church Home & Hosp.</u>	
18. CAUSE OF DEATH <u>4419 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>? LEAK from AORTIC GRAFT</u> <u>CLOTS IN RT FEMORAL ARTERY</u> DUE TO, OR AS A CONSEQUENCE OF: <u>RENAL SHUTDOWN</u> <u>LEAKING AORTIC ANEURYSM.</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>12.6.69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>LEAKING AORTIC ANEURYSM & CLOTS RT FEMORA</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>12.6.69</u> to <u>12.6.1969</u> that (I) (we) last saw the deceased alive on <u>12.6.1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Prabir K. Bose</u> M.D.		23B. DATE SIGNED <u>12.6.69</u>		23C. PHYSICIAN'S NAME (Type) <u>PRABIR K. BOSE</u> M.D.	
23D. ADDRESS <u>Church Home & Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/10/69</u>	
24C. NAME of CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>		24D. LOCATION (City, town, or county) <u>Elkridge RTD. Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1969</u>	
24F. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		24G. FUNERAL DIRECTOR <u>Singleton Funeral Home</u>		24H. ADDRESS <u>4100 Baltimore, Md.</u>	

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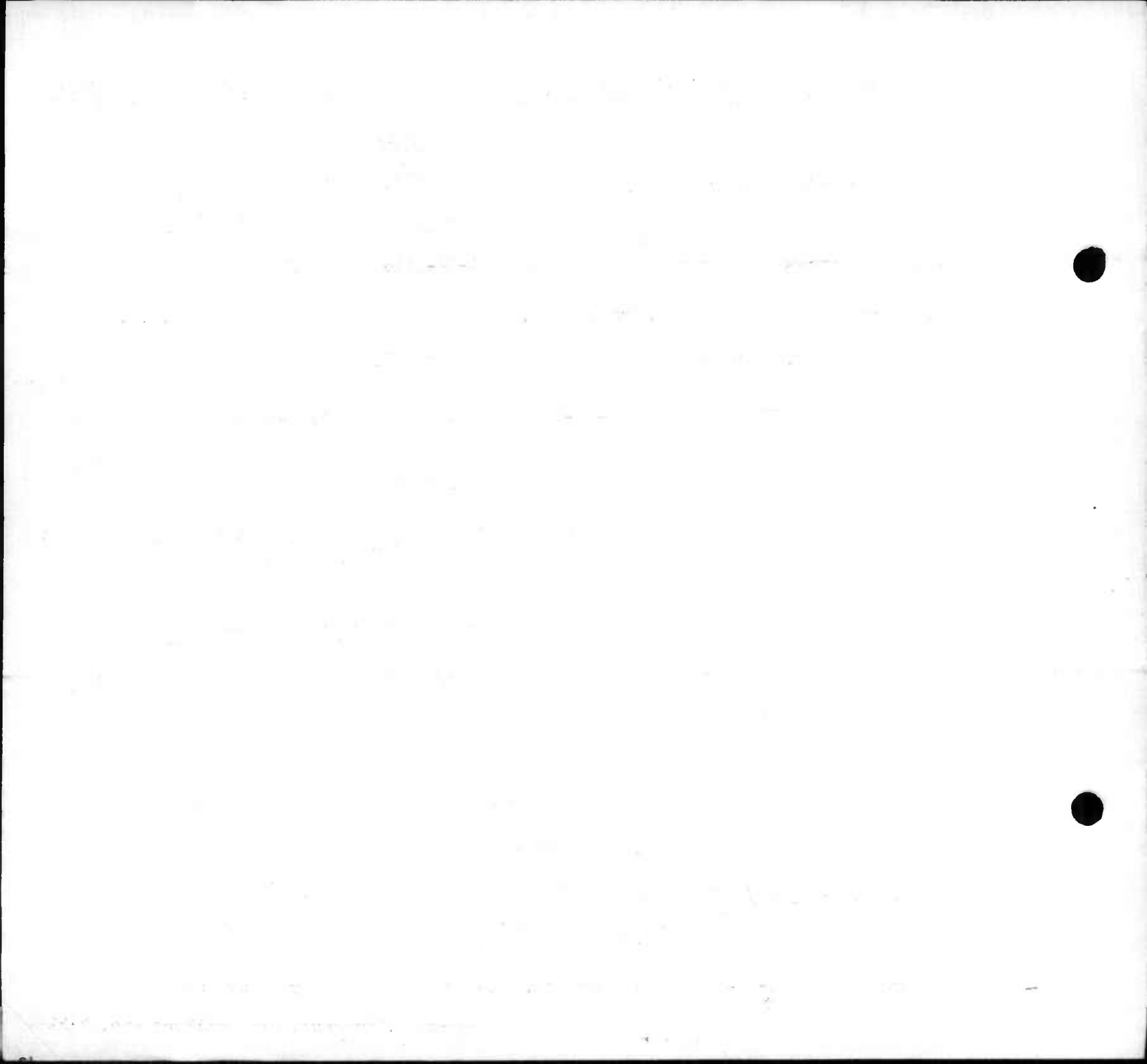
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12187	
69 12187				CERTIFICATE OF DEATH	
BIRTH NO. E-640					
1. NAME OF DECEASED (Type or Print) DEAN J. EARLE			2. DATE AND HOUR OF DEATH 12/5/69 1 8 30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 37 MERCY Hospital			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2582		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 3131 Wilkens Avenue		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-27-87	9. AGE (In years last birthday) 82	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME Nathan Dize			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Jennie D. Ash, 3131 Wilkens Ave. 21229
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			(A) IMMEDIATE CAUSE Shock - heart failure DUE TO, OR AS A CONSEQUENCE OF:		
			(B) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 12/5 19 69 to 12/5 19 69 that (we) last saw the deceased alive on 12/5 19 69 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C.V. Linn			23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Constantine J. Linn
			23D. ADDRESS MERCY Hospital		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-1969		24C. NAME OF CEMETERY or CREMATORY Western Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

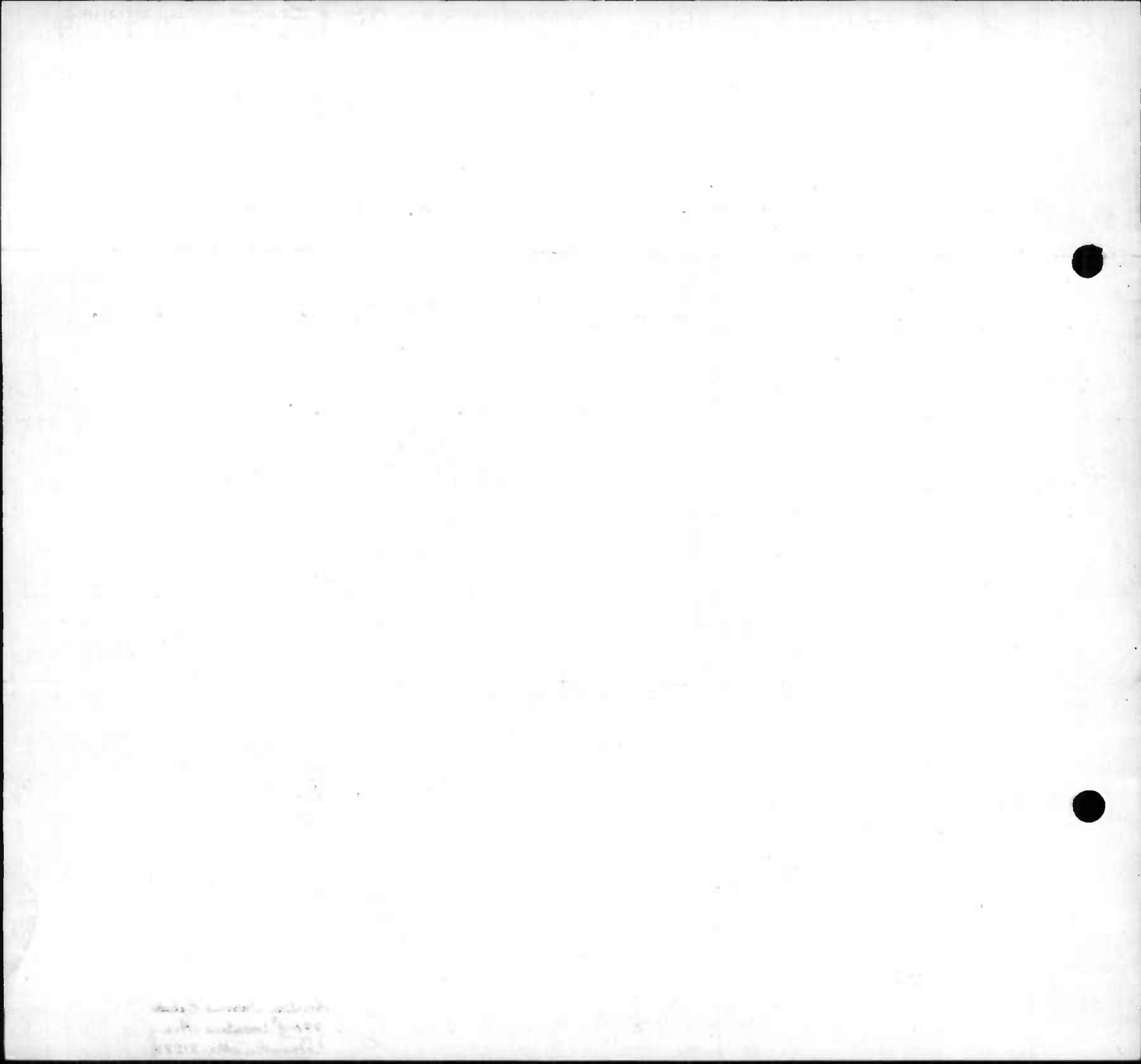
P-626		69 12188		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO.		69 12188	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) RAYMOND J. PARKER				2. DATE AND HOUR OF DEATH 12-5-69 8²¹/P.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore				5. CITY OR TOWN Balto Highlands D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION 48 Maryland General Hospital				E. STREET AND NUMBER 4433 Fenor Rd							
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1916	9. AGE (in years last birthday) 53	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur				10B. KIND OF BUSINESS OR INDUSTRY Balto. Transit Co.							
13. FATHER'S NAME James G. Parker				14. MOTHER'S MAIDEN NAME Dora E. Foutz							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II				16. SOCIAL SECURITY NO. 229-12-2562		17. INFORMANT Mrs. Elizabeth A. Parker, 4433 Fenor Road				ADDRESS 21227	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				(A) IMMEDIATE CAUSE acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF: hours				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) atherosclerotic coronary vasculature DUE TO, OR AS A CONSEQUENCE OF: dissected				4/25			
(C) _____											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				hypostatic bronchopneumonia @							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (1) (this hospital) attended the deceased from 12-5-1969 to 12-5-1969 that (1) (we) last saw the deceased alive on 12-5-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Salvatore R. Donohue M.D.				23B. DATE SIGNED							
23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE M.D.				23D. ADDRESS Maryland General Hosp.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-69		24C. NAME of CEMETERY or CREMATORY Baltimore Nat. Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969				25B. NAME OF REGISTRAR Robert E. Fisher M.D.				25C. FUNERAL DIRECTOR Howard H. Hubbard ADDRESS 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

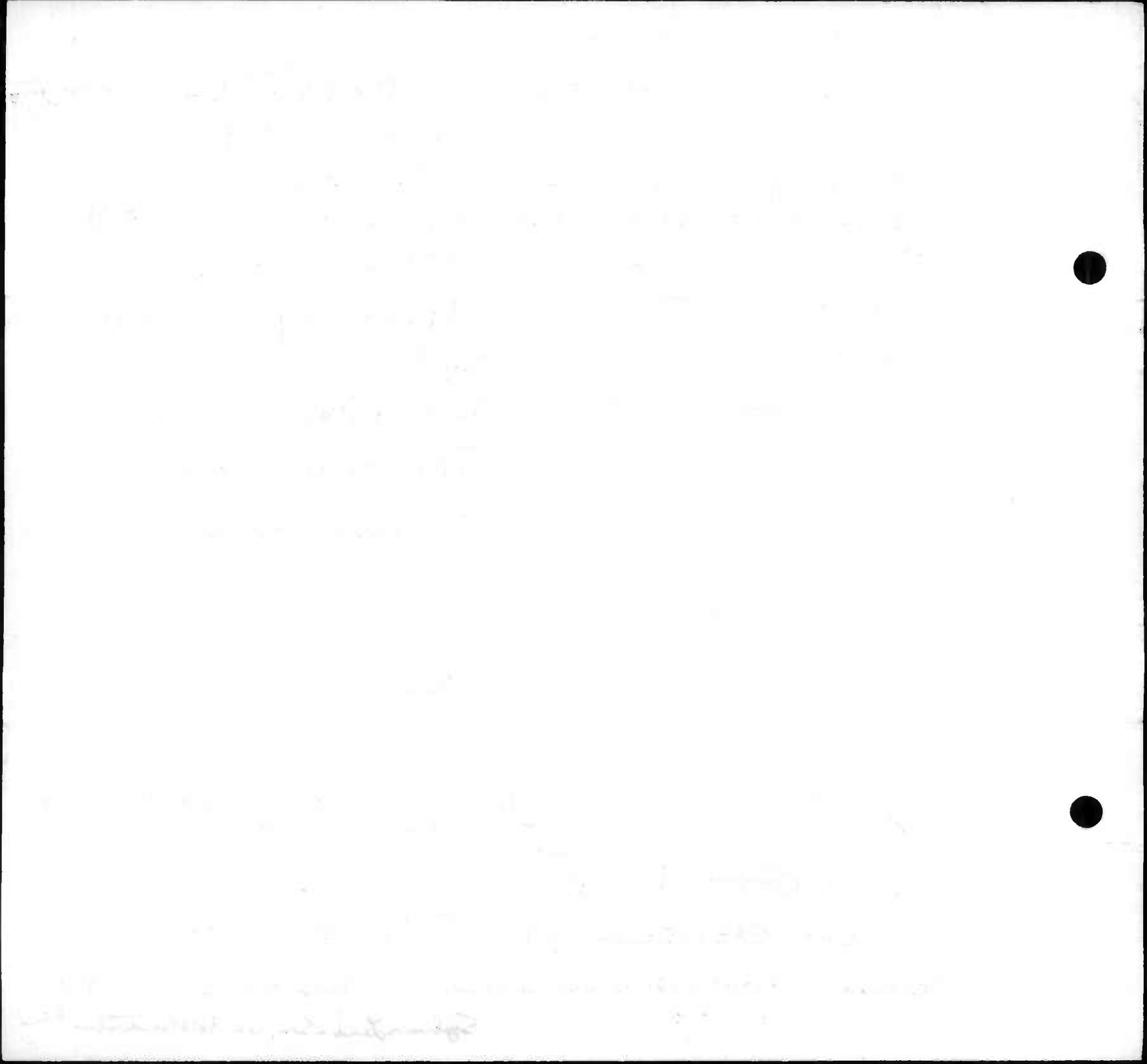
V-544		69 12189		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12189	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				JEANNETTE S. Van LILL			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
100 W. Cold Spring Lane Apt. 109W				Maryland 2711			
5. SEX				6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
Female				White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife						Baltimore, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
James W. Sindall				Mary Blanche Smick			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				---		Dr. Stephen J. VanLill-3601 Greenway	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH			
440.9 I				Anteriosclerosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from November 1962 to 7 Dec 1969, that (I) (we) lost saw the deceased alive on 7 Dec 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
W. J. Helms				8 Dec 69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/10/69		New Cathedral Cemetery		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 10 1969		Robert E. Feltz, MD		Sterling Funeral Estate		936 Edmondson Ave. Catonsville, Md. 21228	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

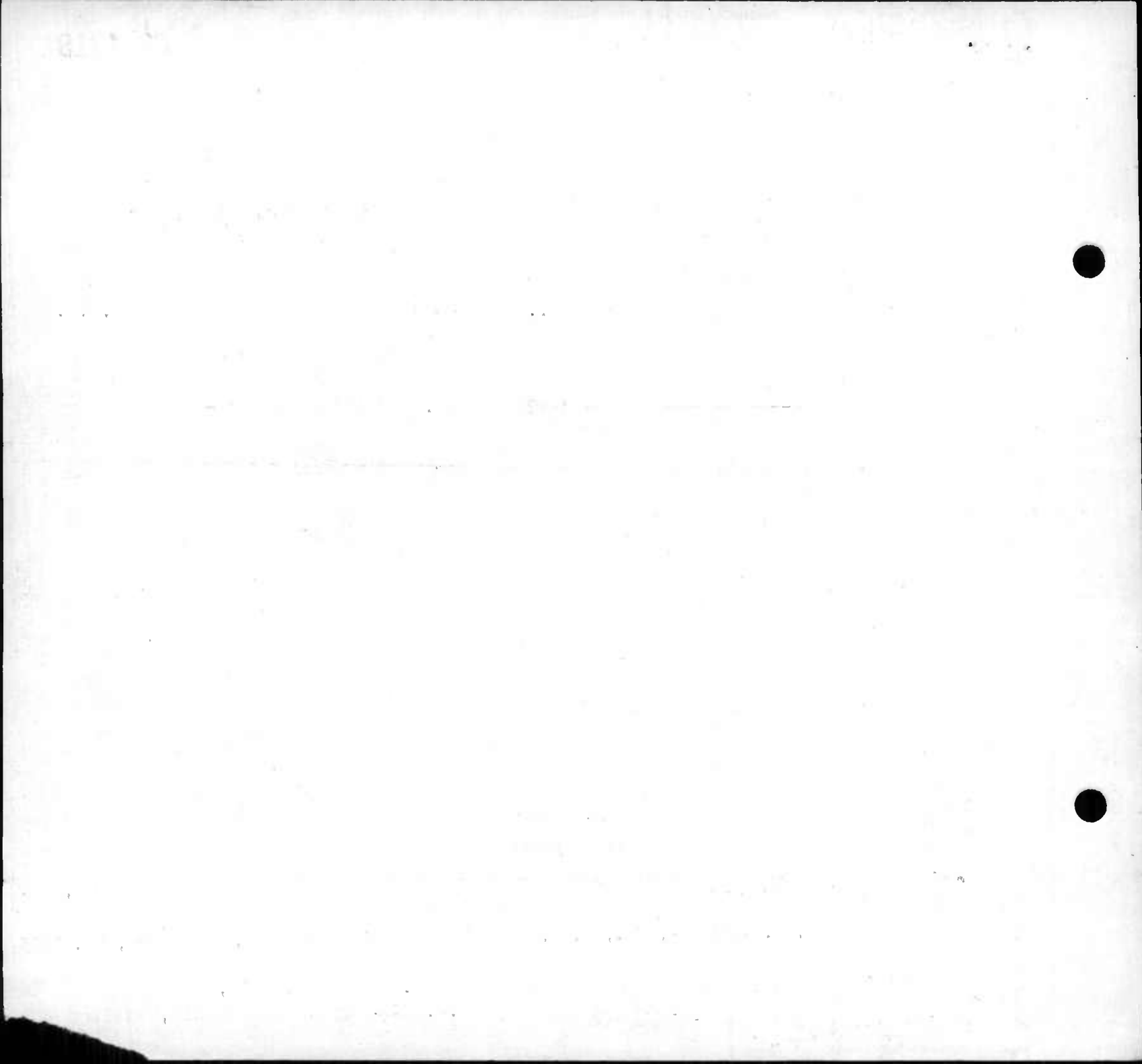
M-534 69 12190		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12190	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRIDA MENDEL		2. DATE AND HOUR OF DEATH Dec 7 '69 (2:50 AM) M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2755		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE, MARYLAND		E. STREET AND NUMBER 5733 Rockspring Rd #9			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-7-83	9. AGE (In years last birthday) 86 years	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert		14. MOTHER'S MAIDEN NAME Sophie	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] NO		16. SOCIAL SECURITY NO.		17. INFORMANT M. Herman Mendel ADDRESS Same	
18. 199.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.) TERMINAL STATE		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinomatous		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 11-28-69 to 12-7-69 that (X) (we) last saw the deceased alive on 12-6-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE San Gabriel MD		23B. DATE SIGNED 12-7-69		23C. PHYSICIAN'S NAME (Type) I. SAN GABRIEL MD	
23D. ADDRESS SINAI HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/69		24C. NAME OF CEMETERY or CREMATORY Cherry Avenue Closed	
24D. LOCATION (City, town, or county) (State) Randalltown Md					
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sylvan L. & Son, Inc. 9610 Rockledge Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 6810
W-460 69 12191				69 12191
BIRTH NO.		1		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
Wheeler, Elmer		December 8, 1969 1 a M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY		
The Johns Hopkins Hospital		Maryland Anne Arundle 5200		
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Glen Burnie		YES <input type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		1210 Wilson Road		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	6/8/10	59
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Welder		Koppers Co.		Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		
William Wheeler		Virginia Weaver		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no		212-03-4493		Mrs. Virginia Wheeler -Same as # 4
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES		Progressive renal failure 2 months		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Unknown etiology		
		(C)		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2				YES
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
				NO
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (X) (this hospital) attended the deceased from Nov 28 19 69 to Dec 8 19 69, that (X) (we) last saw the deceased alive on December 7 19 69 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
N. F. Adkinson, Jr., M.D.				December 8, 1969
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
N. F. Adkinson, Jr., M. D.		Johns Hopkins Hospital, Baltimore, Md. 21205		
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)
Burial	12/11/69	Glen Haven Memorial Pk.		Glen Burnie, Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 10 1969	Robert F. ...		Rov. Singleton/Glen Burnie, Maryland	



T-600 69 12192

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12192

BIRTH NO.

1. NAME OF DECEASED (Type or Print) JOHN TURI		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month December Day 3 Year 1969 Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Union Memorial Hospital (DOA)		3. DATE PRONOUNCED DEAD Month December Day 3 Year 1969 Hour 11:15 P.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 905		6. SEX Male 7. RACE White 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
9. DATE OF BIRTH 2-6-1912 10. AGE (In years last birthday) 57 11. BIRTHPLACE (State or foreign country) Windber, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A. 13. FATHER'S NAME unknown	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ship-Captain 14B. KIND OF BUSINESS OR INDUSTRY Merchant Marine		15. MOTHER'S MAIDEN NAME unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-14-2225 18. INFORMANT ADDRESS Maliszewski Funeral Home South River, N.J.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) OF INJURY	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED December 4, 1969 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-1969 24C. NAME OF CEMETERY or CREMATORY Monumental Cemetery 24D. LOCATION (City, town, or county) (State) South River, New Jersey	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204	

E-350

69 12193

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12193

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WALTER J. EATON (Juneau)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> December 5, 1969		Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 2412 Pressbury St.		3. DATE PRONOUNCED DEAD December 5, 1969		Month Day Year Hour		9:44 P.M.	
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission) A. STATE Maryland B. COUNTY 1503	
9. DATE OF BIRTH 4-9-1910		10. AGE (In years last birthday) 59		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John B. Eaton		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		15. MOTHER'S MAIDEN NAME Annie Yelity		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. 216-03-7965		18. INFORMANT Beatrice Eaton		ADDRESS Same		19. 412.2 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Hypertensive cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-6-69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-69		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Gentry		25C. FUNERAL DIRECTOR Walter J. Phillips		ADDRESS 1727 N. Mount St.	

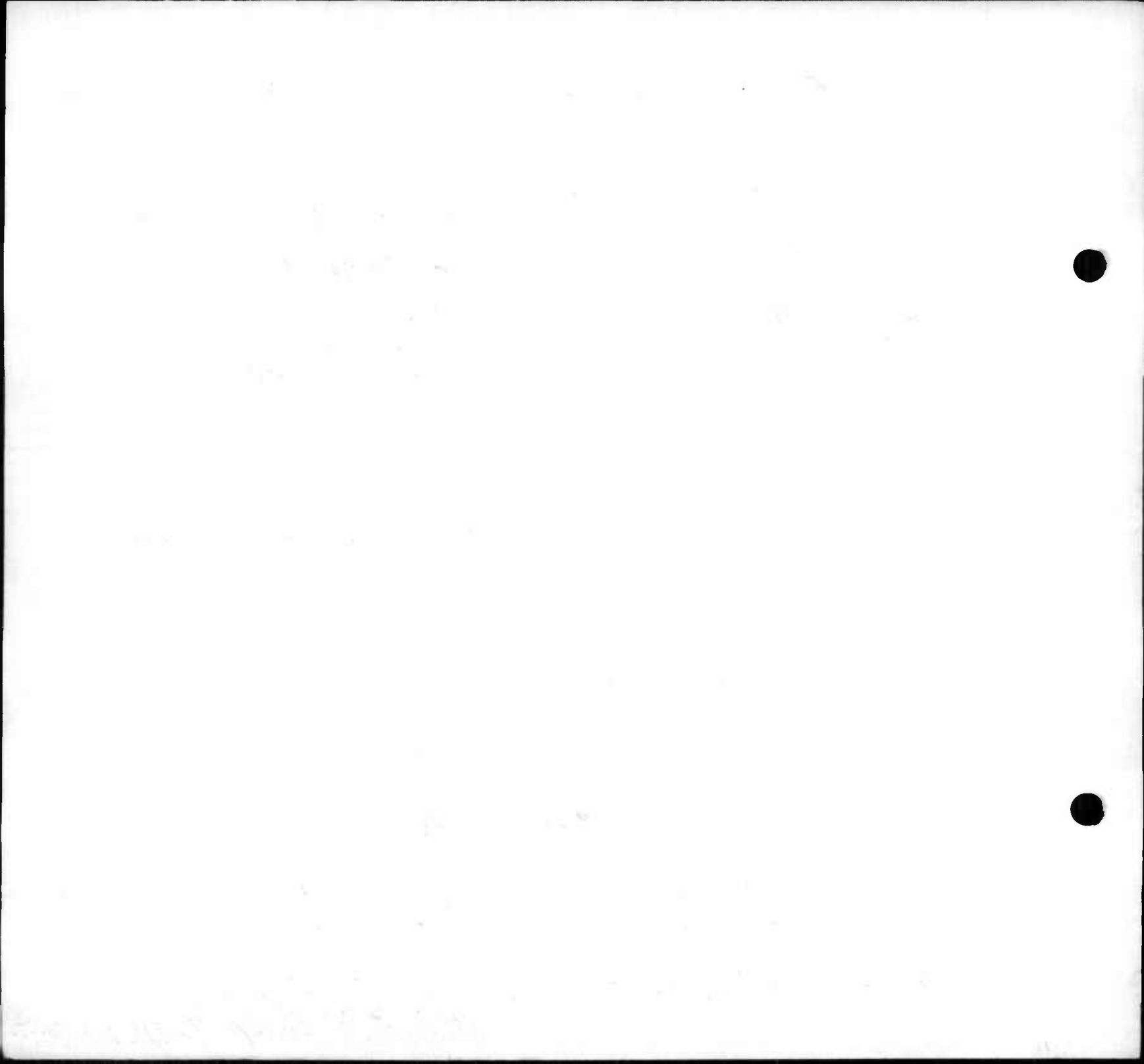
WILSON PAPERS CO.

ACADEMIC RECORD

MADE IN U.S.A.

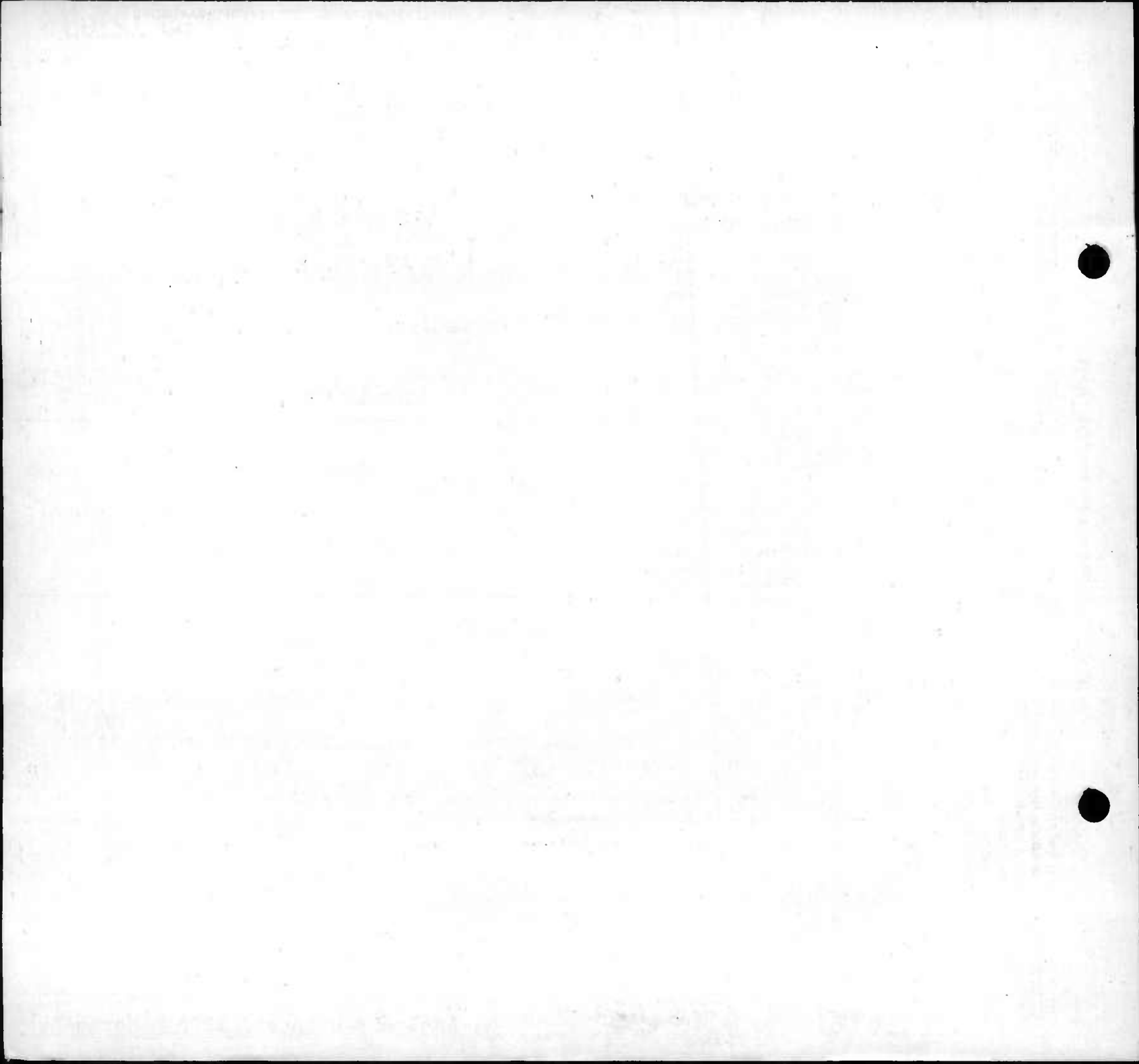
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-210		69 12194		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12194	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) BISHOP, RUTH J.				2. DATE AND HOUR OF DEATH 12-5-69 12:20 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 SINAI HOSPITAL OF BALTIMORE				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 1702				C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE				E. STREET AND NUMBER 1216 McCulloh St. #17					
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb - 2/20/92 77	9. AGE (In years last birthday) 77	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10B. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME Bennett F. Sewell				14. MOTHER'S MAIDEN NAME Annie Bagwell					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Ruth Posey		ADDRESS Same	
18. 575-X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIO RESPIRATORY FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. EMPHYSEMA OF GALL BLADDER				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIO RESPIRATORY FAILURE (B) DUE TO, OR AS A CONSEQUENCE OF: EMPHYSEMA OF GALL BLADDER (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 12-2-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED EMPHYSEMA OF GALL BLADDER		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-2-69 to 12-5-69 that (I) (we) last saw the deceased alive on 2:12 pm 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-5-69			
23C. PHYSICIAN'S NAME (Type) CHARO A. PRO RIDA, MD				23D. ADDRESS SINAI HOSPITAL OF BALTIMORE					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-69		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore MD			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR [Signature]		ADDRESS 1727 N. Mount St.			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-260		69 12195		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12195	
BIRTH NO.				2			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
REBECCA TUCKER				12/9/69 2 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				A. STATE B. COUNTY			
90 KENSON NURSING HOME 2922 Arunah Ave				Maryland 1606			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> F C WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH				E. STREET AND NUMBER			
1883 86				2922 Arunah Ave			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
NONE				NONE			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
?				?????			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				214-54-2701		Mr Leon Jordan, 2633 Beryl Ave	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Cardio-Vascular Disease			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Several years			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
NONE						NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan. 4, 1969 to Dec. 9, 1969, that (I) (we) last saw the deceased alive on Dec. 8, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Frank N. Ogden, M.D.						Dec. 10, 1969	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
FRANK N. OGDEN, M.D.						2701 N. Calvert St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/12/69		Roxboro		North Carolina	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 10 1969		Rebecca E. Taylor		Adolphus Halstead		1206 W North Ave	



2-652
K 626

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 12196 CERTIFICATE OF DEATH

REG. NO.

69 12196

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Thomas Zuromski

Thomas Zuromski (Krieger)

2. DATE AND HOUR OF DEATH

9 Dec 69

6 22 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

514 Rappolla St. #21224 007

5. SEX

Male

6. RACE

White

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

10-28-98

9. AGE (In years
last birthday)

71

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Tavern Operator

10B. KIND OF BUSINESS OR INDUSTRY

Self-employed
tavern owner

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Albin Zuromski

14. MOTHER'S MAIDEN NAME

Mary Ratajczak

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

W. W. I

16. SOCIAL
SECURITY NO.

215-07-4163

17. INFORMANT

ADDRESS

4940 Eastern Avenue
BCH-Records Baltimore, Maryland 21224

18.

410.9 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Acute coronary thrombosis 30 min

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

no

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐Not While ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from Dec 9 1969 to Dec 9 1969,
that (1) (we) last saw the deceased alive on Dec 9 1969 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

David J. Riley MD

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

9 Dec 69

23C. PHYSICIAN'S
NAME (Type)

David J. Riley

MD

23D. ADDRESS

4940 Eastern Avenue

BCH Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/13/69

24C. NAME OF CEMETERY OR CREMATORY

St. Stanislaus Cemetery

24D. LOCATION (City, town, or county) (State)

6515 Boston Avenue
Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 10 1969

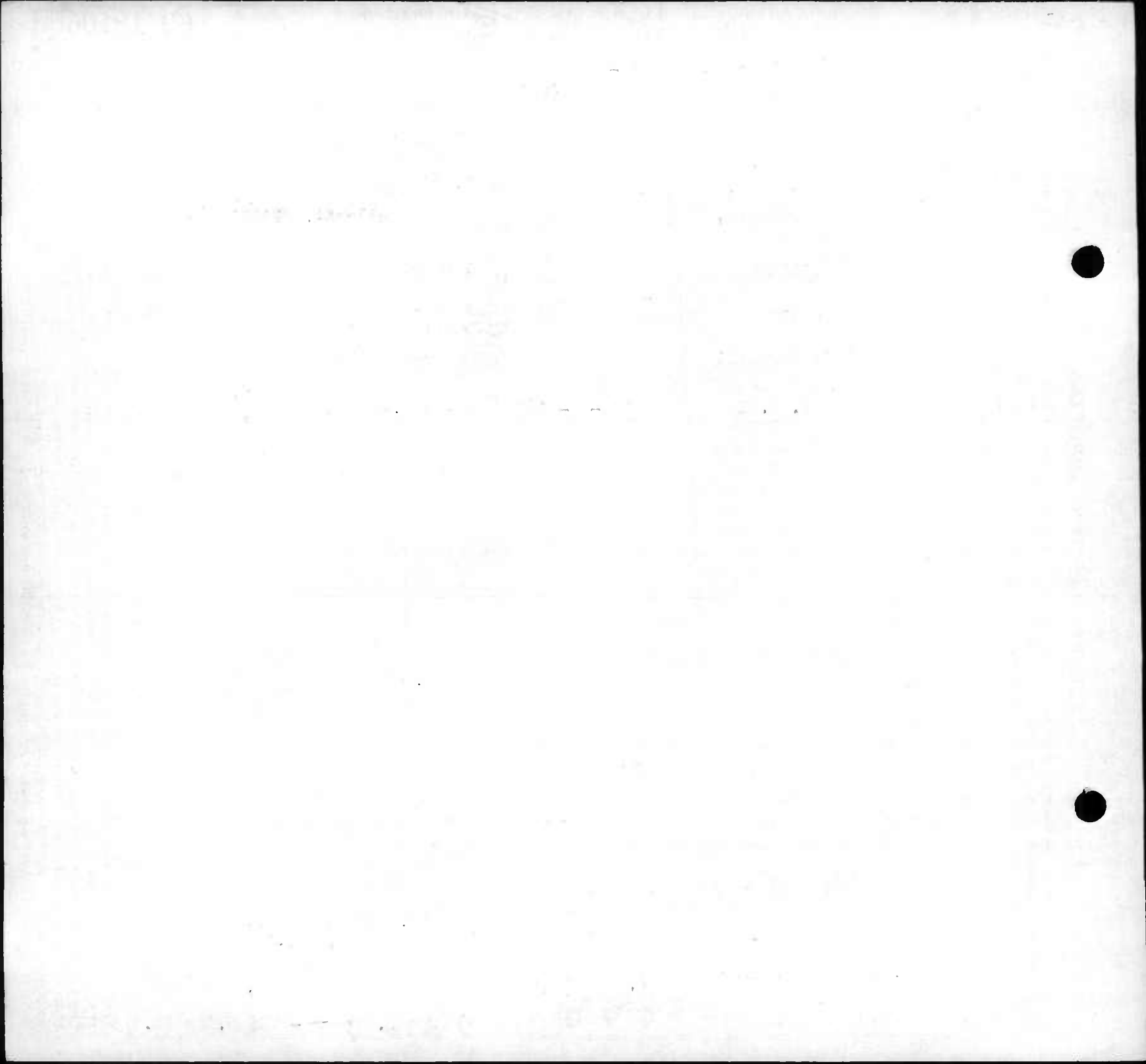
25B. NAME OF REGISTRAR

George A. Weber

25C. FUNERAL DIRECTOR

George A. Weber - 705 S. Ann St. #21231

ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12197
69 12197		CERTIFICATE OF DEATH		
BIRTH NO.		2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) STELLA LOHINSKI		December 8, 1969 8 ¹⁵ P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 00		A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 6 North Potomac Street		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER 6 N. Potomac Street		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/19/84	9. AGE (In years last birthday) 85
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (State or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Frank Brukiewa		14. MOTHER'S MAIDEN NAME Rosalie ??		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No -		16. SOCIAL SECURITY NO. 212-05-9308		17. INFORMANT Miss Stella Lohinski
		ADDRESS 6 N. Potomac St.		
18. 43791		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pneumonia		1 day
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) restrictive disease of throat DUE TO, OR AS A CONSEQUENCE OF:		years
		(C) cerebral atherosclerosis		years
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 10/3 19 68 to 12/8 19 69 , that (I) (did) last saw the deceased alive on 12/3 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Herbert A. Kushner				23B. DATE SIGNED 12/10/69
23C. PHYSICIAN'S NAME (Type) Herbert A. Kushner, M.D.		23D. ADDRESS 2 East Read Street Balto., Md. 21202		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/12/69	24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE

unusually

with the same intention
and the same result

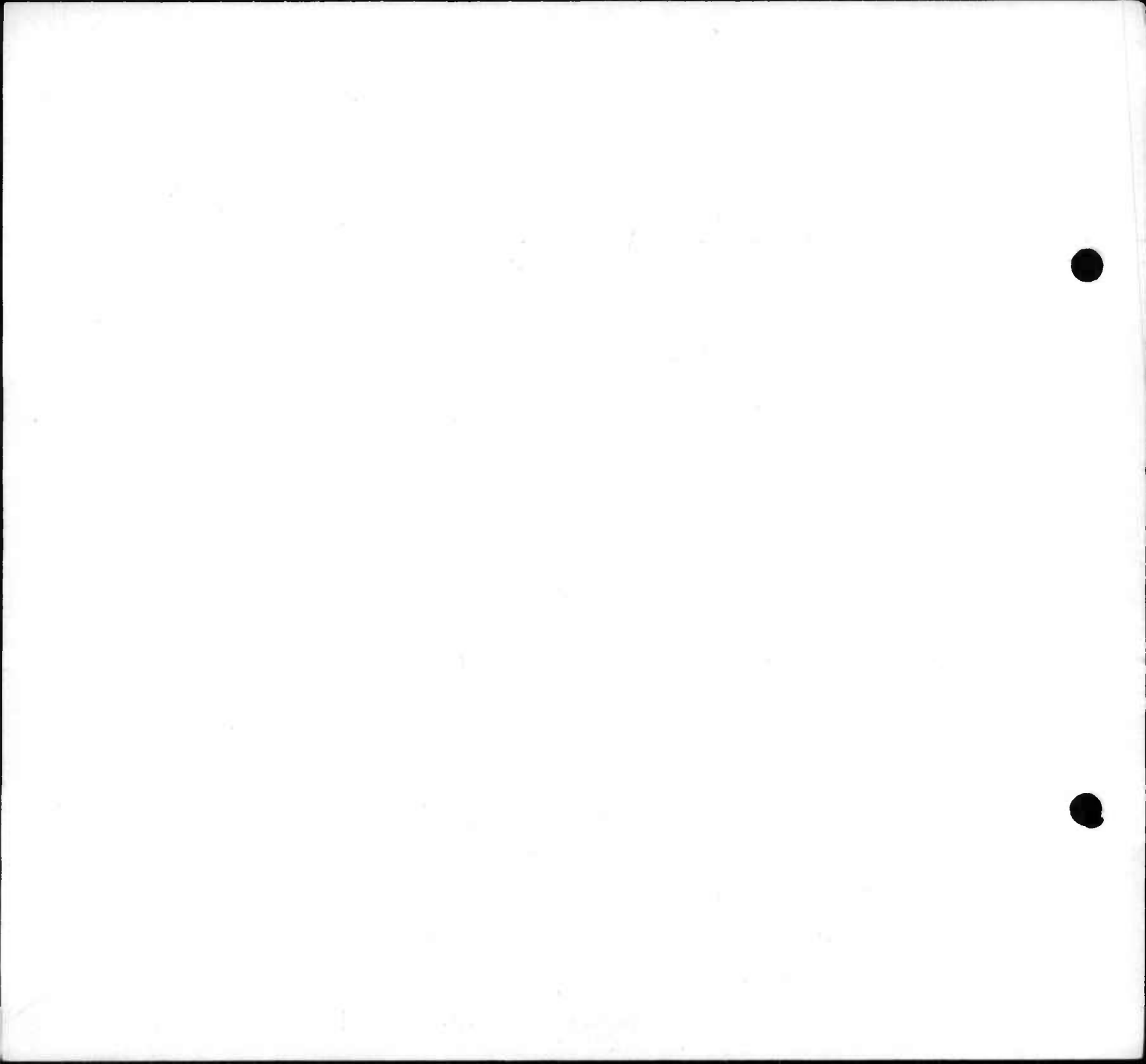
10/10

10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		69 12198		REG. NO. 69 12198	
BIRTH NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Nelson W. Graenhalgh</u>		2. DATE AND HOUR OF DEATH <u>8 December 1969</u> <u>704 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>35 CHURCH HOME AND HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>301</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>1634 E. BALTIMORE ST.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>4/29/02</u>	9. AGE (in years last birthday) <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Polisher</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Silverware</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>William D. Greenhalgh</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>109-03-3673</u>		17. INFORMANT <u>Mrs. Anna Hackett, 244 S. Washington St.</u>	
18. <u>23 01 71</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 hour</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>1 hour</u>	
		(C) <u>diabetes mellitus</u>		<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>atherosclerosis</u>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>8 December 1969</u> to <u>8 December 1969</u> that (I) (we) last saw the deceased alive on <u>8 December 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <u>(did)</u> <u>(did not)</u> view the body after death.					
23A. SIGNATURE <u>Donald E. Fisher M.D.</u>		23B. DATE SIGNED <u>9 December 69</u>		23C. PHYSICIAN'S NAME (Type) <u>Donald E. Fisher</u>	
23D. ADDRESS <u>Church Home & Hospital</u>		23E. FUNERAL DIRECTOR <u>M. J. SADOVSKI & SONS, 1808 Eastern Ave</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/12/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore, National</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. ADDRESS <u>Baltimore, Maryland</u>			
25A. DATE RECEIVED BY HEALTH DEPT. <u>DEC 10 1969</u>		25B. NAME OF REGISTRAR <u>John E. Fisher, M.D.</u>		25C. ADDRESS <u>Baltimore, Maryland</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12199	
<p>BIRTH NO. Jones 69 12199</p> <p>1. NAME OF DECEASED (Type or Print) Jones, Willie M.</p>		<p>CERTIFICATE OF DEATH</p>			
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Lutheran Hospital of Maryland</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46</p>		<p>2. DATE AND HOUR OF DEATH 12-5-69 5 45 M.</p> <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE 3215 Carlisle Avenue B. COUNTY 1537</p> <p>C. CITY OR TOWN Baltimore, M.D. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER</p>			
<p>5. SEX Female</p>	<p>6. RACE AC</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 9-15-99</p>	<p>9. AGE (In years last birthday) 70</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (State or foreign country) South Carolina</p>	
<p>13. FATHER'S NAME Sam Brice</p>		<p>14. MOTHER'S MAIDEN NAME Annie Moore</p>			
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT Geneva Martin ADDRESS 3215 Carlisle Ave</p>	
<p>18. 1977.8 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>CAUSE OF DEATH Respiratory Failure</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hepatic Coma</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma of Liver</p> <p>(C) Dehydration, jaundice.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No)</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>		<p>21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 12/5/1969 to 12/5/1969, that (I) (we) last saw the deceased alive on 12/5/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE Subash C. Ahuja M.D.</p>				<p>23B. DATE SIGNED 12/5/69</p>	
<p>23C. PHYSICIAN'S NAME (Type) SUBASH C. AHUJA, M.D.</p>				<p>23D. ADDRESS Lutheran Hosp.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 13-9-69</p>		<p>24C. NAME OF CEMETERY OR CREMATORY Woodward</p>	
<p>24D. LOCATION (City, town, or county) (State) S.C</p>		<p>25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969</p>			
<p>25B. NAME OF REGISTRAR Robert E. Taylor, Jr.</p>		<p>25C. FUNERAL DIRECTOR ADDRESS Rayner Sanders 217 E. Preston St</p>			

Responsible Person

Responsible Person

Responsible Person

Responsible Person

12/21

12/21

12/21

12/21

12/21

12/21

12/21

12/21

12/21

1
F-363

BALTIMORE CITY HEALTH DEPARTMENT

69 12200 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12200

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LOSSIE (LASSIE) EDWARDS		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> December 6, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 001403 E. Lanvale St.		3. DATE PRONOUNCED DEAD Month Day Year Hour December 6, 1969 1:10 A M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 909			
6. SEX Female	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore
D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH 5-7-15	10. AGE (In years last birthday) 54	If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
E. STREET AND NUMBER 1403 E. Lanvale St.			
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Anderson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Lula CRANDEL		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO	
17. SOCIAL SECURITY NO.		18. INFORMANT MARY WIGGINS	
ADDRESS 2722 E. Federal			
19. 571.01 + 158.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Laennec's cirrhosis		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20. DATE OF OPERATION 2		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-6-69			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-10-69	
24C. NAME of CEMETERY or CREMATORY MT AYBURN CEM		24D. LOCATION (City, town, or county) (State) BALTO. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Farber, M.D.	
25C. FUNERAL DIRECTOR Marshall Jones		ADDRESS 1135 Hanford Ave	

VS177-Dr.Springate

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

George J. Scheuerman

2. DATE AND HOUR OF DEATH

12/5/69 12:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hosp. 21224
4940 Eastern Avenue, Baltimore, Maryland

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE Maryland B. COUNTY Baltimore

C. CITY OR TOWN Essex

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

Rt. 14, Box 32 21220

5. SEX

Male

6. RACE

White

7. MARRIED

NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12/8/89

9. AGE (in years)

lost birthday 79

10. Under 1 Yr.

Months Days

11. Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Scheuerman

14. MOTHER'S MAIDEN NAME

Elizabeth ?

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

16. SOCIAL SECURITY NO.

218-26345

17. INFORMANT

Records: BCH-4940 Eastern Avenue 21224

ADDRESS

18. ~~28871X~~

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(C) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

19A. DATE OF OPERATION

3/12/13/65

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

F-xip + tip

20A. AUTOPSY? (Yes or No)

POST

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

Home

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Rt 14, Box 32 53-00

21D. TIME OF INJURY (APPROX.)

11/10/69

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR?

P + fell near steps

22. I certify that (I) (this hospital) attended the deceased from 11/10/69 to 12/5/69 and that (I) (we) last saw the deceased alive on 12/5/69 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jose E. Ortiz Diaz

DEGREE

Attending Phys. ☒Med. Director ☐Staff Phys. ☐

23B. DATE SIGNED

12/5/69

23C. PHYSICIAN'S NAME (Type)

Jose E. Ortiz Diaz

DEGREE

23D. ADDRESS

6044 EAST PRATT ST. BALTIMORE MD.

24A. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12/9/69

24C. NAME OF CEMETERY or CREMATORY

HOLY REDEEMER

24D. LOCATION

BALTO. MD.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 10 1969

25B. NAME OF REGISTRAR

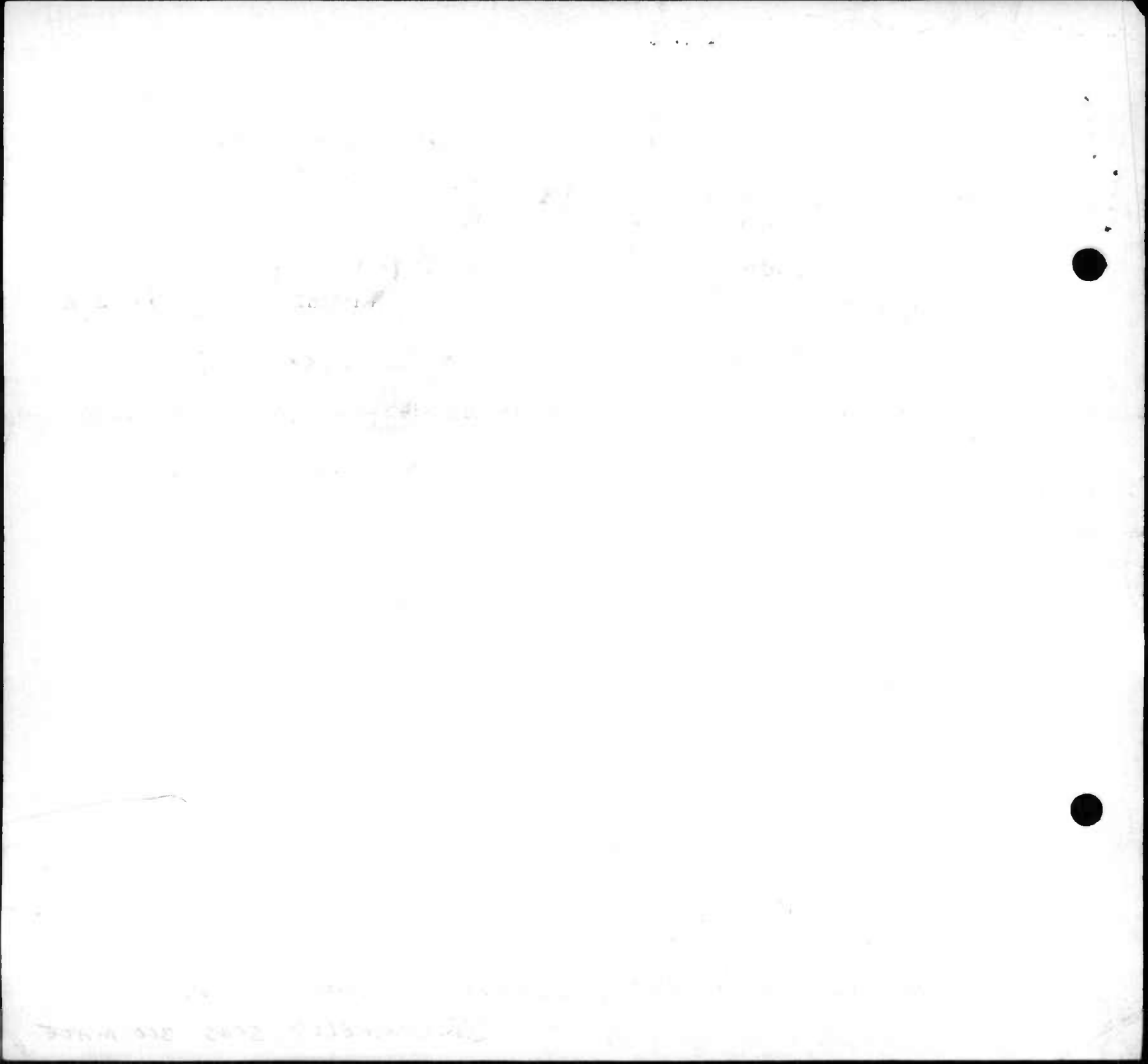
Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

J.B. CONNELLY SONS

ADDRESS

300 MACE



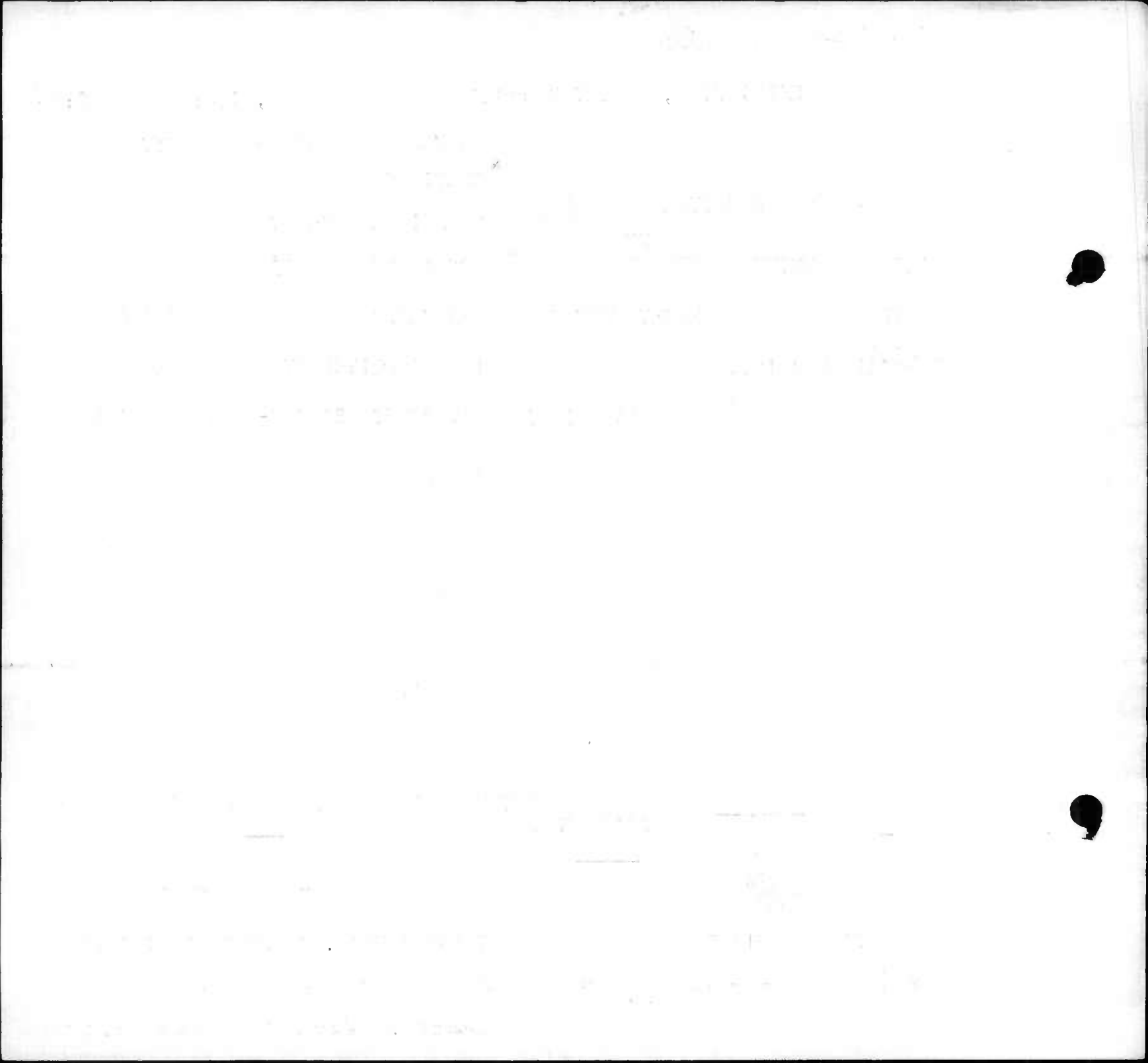
1

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
7-560 69 12202		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		69 12202	
1. NAME OF DECEASED (Type or Print) CLYDE R. RAMER		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 5, 1969		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year December 5, 1969		Hour M. 11:10 A.	
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 12/22/24		10. AGE (In years last birthday) 44		11. BIRTHPLACE (State or foreign country) MISS	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WESLEY RAMER		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECURITY	
15. MOTHER'S MAIDEN NAME ADDIE McCARTER		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II		17. SOCIAL SECURITY NO. 414-20-424	
18. INFORMANT ELLA RAMER		ADDRESS ABOVE		19. CAUSE OF DEATH E-812.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple blunt injuries (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Back River Neck Road 5300 666 feet south of Hyde Park Rd.	
22D. TIME OF INJURY (APPROX.) 12-5-69 10:45 A		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Driver of auto which hit truck head-on	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 12-6-69					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/9/69		24C. NAME OF CEMETERY or CREMATORY BALTO. NATL. CEM.	
24D. LOCATION (City, town, or county) (State) BALTO. M.D.		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Sabin, R.D.	
25C. FUNERAL DIRECTOR J.G. GONNELLY SONS		ADDRESS 300 MACE		25D. NAME OF REGISTRAR J.G. GONNELLY SONS	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

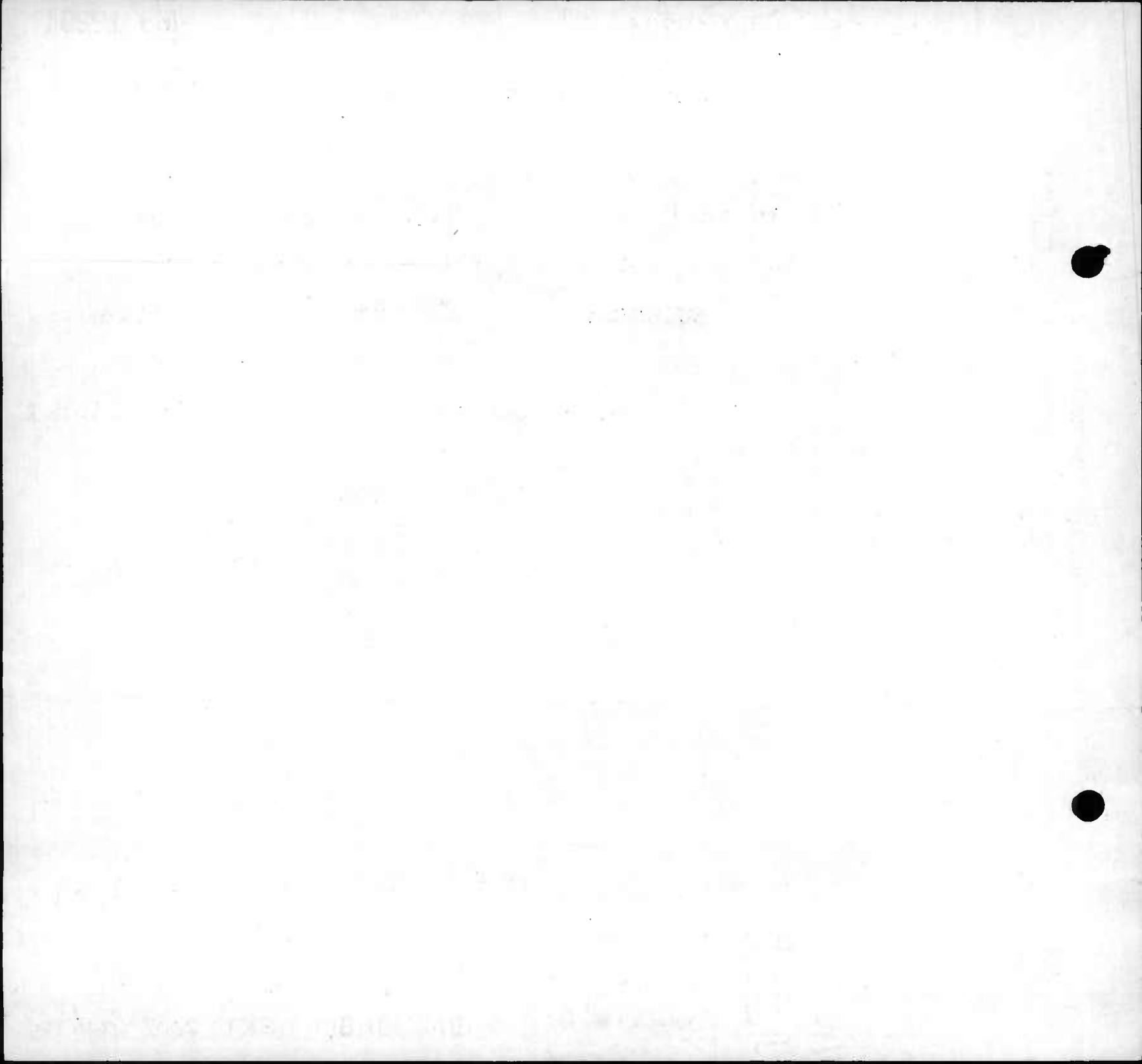
H-652		69 12203		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		69 12203		
BIRTH NO.					2. DATE AND HOUR OF DEATH					
1. NAME OF DECEASED (Type or Print) HARRINGTON, ROBERT RANDOLF					DECEMBER 8, 1969 1 6:00 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL					A. STATE MARYLAND B. COUNTY BALTIMORE COUNTY 5300					
					C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
					E. STREET AND NUMBER 2 DAVID LEE COURT					
5. SEX MALE		6. RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 05 29 96		9. AGE (In years last birthday) 73		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY MAY HECHT CO		11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME FRANK HARRINGTON					14. MOTHER'S MAIDEN NAME Isadora Pritchett					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO					16. SOCIAL SECURITY NO. 218 03 8360		17. INFORMANT ST AGNES RECORDS-BALTO MD 21229			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.41 !This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident (B) AS CVD (Arteriosclerotic Cardiovascular) DUE TO, OR AS A CONSEQUENCE OF: Disease (C) Anemia of Unknown Origin					
19. DATE OF OPERATION 0					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH Indify medical examined <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED White At Work <input type="checkbox"/> Nat White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 16 19 69 to DECEMBER 8 19 69 that (I) (we) last saw the deceased alive on DECEMBER 8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE 					23B. DATE SIGNED 10 12 08 69					
23C. PHYSICIAN'S NAME (Type) SALVADOR QUIROZ					23D. ADDRESS ST AGNES HOSP. CATON & WILKENS AVE					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-11-1969		24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery			24D. LOCATION (City, town, or county) (State) GlenBurnie, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969					25B. NAME of REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave. 21229			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-352 69 12204 (JOZEFA)				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12204	
1. NAME OF DECEASED (Type or Print) JOSEPHINE R. CHODNICKI				2. DATE AND HOUR OF DEATH 12-8-69 4:00 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 CENTURY NURSING HOME 102 N. PACA ST.				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 21231 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-1-90	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10B. KIND OF BUSINESS OR INDUSTRY CANNERY		11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? POLAND	
13. FATHER'S NAME GEORGE SOBOTKA				14. MOTHER'S MAIDEN NAME ROSALIE MANOWSKA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 212-01-2615		17. INFORMANT STEVE CHODNICKI ADDRESS 713 S. Bethel	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardio Respiratory Failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Coronary Heart Failure Art. CVT Gen. Cerebral Art.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 23 1965 to Dec 8 1965 , that (I) (we) last saw the deceased alive on Dec 8 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Willard Applefeld				23B. DATE SIGNED 12/9/69		23C. PHYSICIAN'S NAME (Type) WILLARD Applefeld MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/69		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cm.		24D. LOCATION (City, town, or county) (State) Balto. Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. J. [illegible]		25C. FUNERAL DIRECTOR WMI. FRACKOWSKI		25D. ADDRESS 2007 Eastern	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-320		69 12205		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12205	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>John J. Hudock</u>				2. DATE AND HOUR OF DEATH <u>12/17/69</u> <u>5:35 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u> Union Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Essex</u> D. INSIDE CITY LIMITS? <u>Baltimore</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>35 B Westway North</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/30/18</u>	9. AGE (in years last birthday) <u>51</u>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder - Owens Yacht Company</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>George Hudock</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>150-14-1070</u>		17. INFORMANT <u>Mrs. Santa J. Hudock, 35 B Westway North, Essex, Md. 21221</u>	
18. <u>423X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Seven Bilateral Pulmonary</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Eczema</u> <u>Pneumonia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MM</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/14/1969</u> to <u>12/17/1969</u> that (I) (we) last saw the deceased alive on <u>12/17/1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ronald Geckler M.D.</u>				23B. DATE SIGNED <u>12/17/69</u>		23C. PHYSICIAN'S NAME (Type) <u>RONALD GECKLER M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>12/11/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Memorial Park</u>	
24D. LOCATION <u>Dorsey, Maryland</u>				25A. DATE REC'D BY HEALTH DEPT. <u>DEC 10 1969</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher, Md.</u>				25C. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>			

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James Buchanan
President
1845-1853

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 69 12206	
H-435 69 12206		CERTIFICATE OF DEATH			
BIRTH NO. 1. NAME OF DECEASED (Type or Print) Maude Helton <i>Helton-Mrs. Maude</i>		2. DATE AND HOUR OF DEATH 12-7-69 11:55 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 Keswick Keswick Nursing Home		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5300 633 Aldworth Road			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-83		9. AGE (in years last birthday) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Layton North Carolina	
13. FATHER'S NAME ? <i>Xendrix</i>		14. MOTHER'S MAIDEN NAME Elmedia X. Kincaid		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 239-10-7237		17. INFORMANT ADDRESS Rachel C. Gibson, P.O. - Keswick	
18. 486 X 1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II Encephalomalacia due to arteriosclerosis				4 years	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from July 30 19 68 to December 7 19 69 , that (we) lost saw the deceased alive on December 7 19 69 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE W.B. Daniels, Jr. M.D. OEGREE				23B. DATE SIGNED 12/8/69	
23C. PHYSICIAN'S NAME (Type) W.B. Daniels, Jr. M.D. OEGREE				23D. ADDRESS Keswick Baltimore 18, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Remov.		24B. DATE 12-10-69		24C. NAME OF CEMETERY OR CREMATORY Lutheran Church Cemetery	
24D. LOCATION (City, town, or county) (State) Gastonia, Gaston, Co. North Carolina					
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. Duda ADDRESS 7922 Wise, Ave Dundalk, Md.	

Handwritten text, possibly a date or reference number.

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Handwritten text, possibly a location or description.

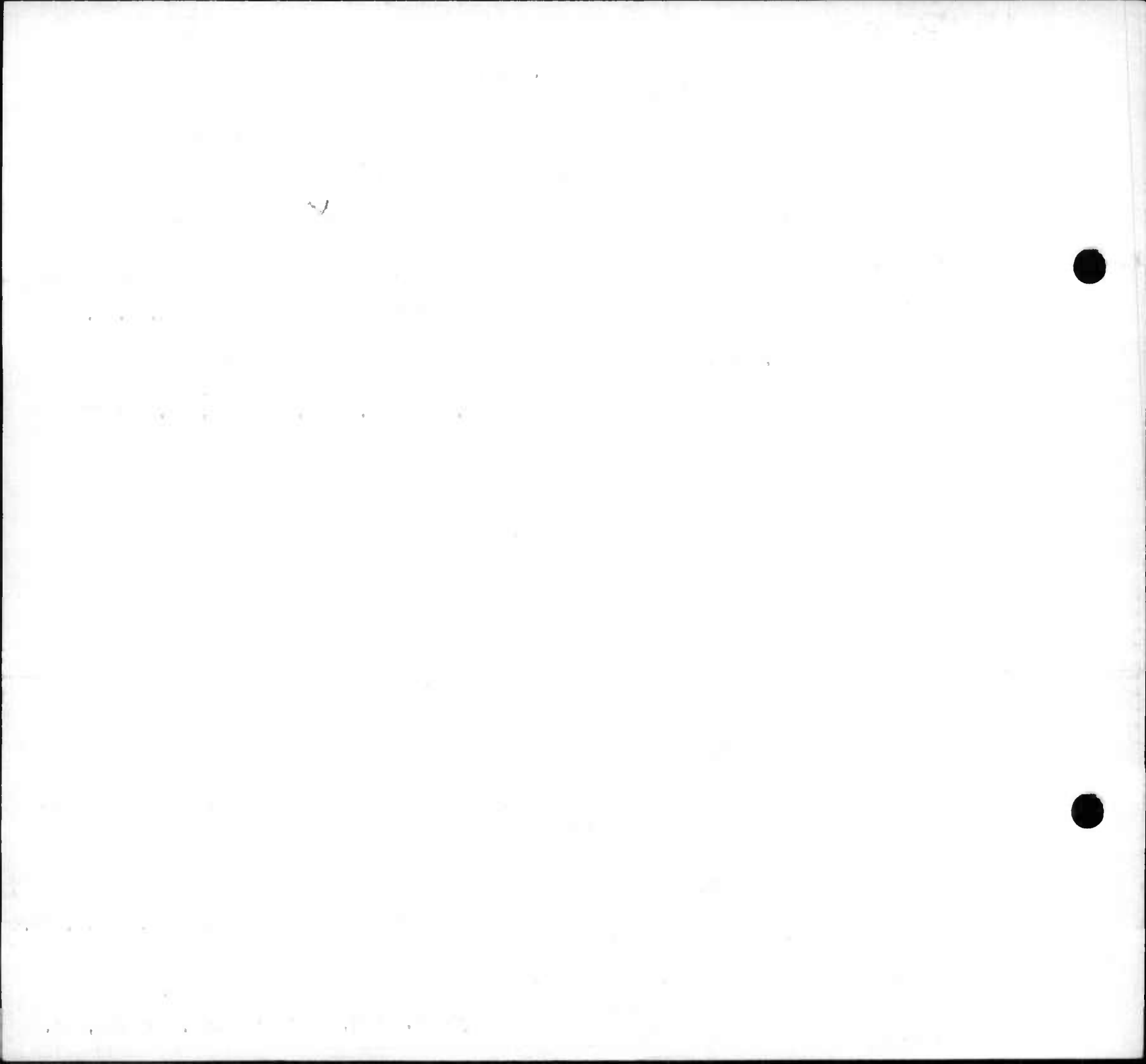
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

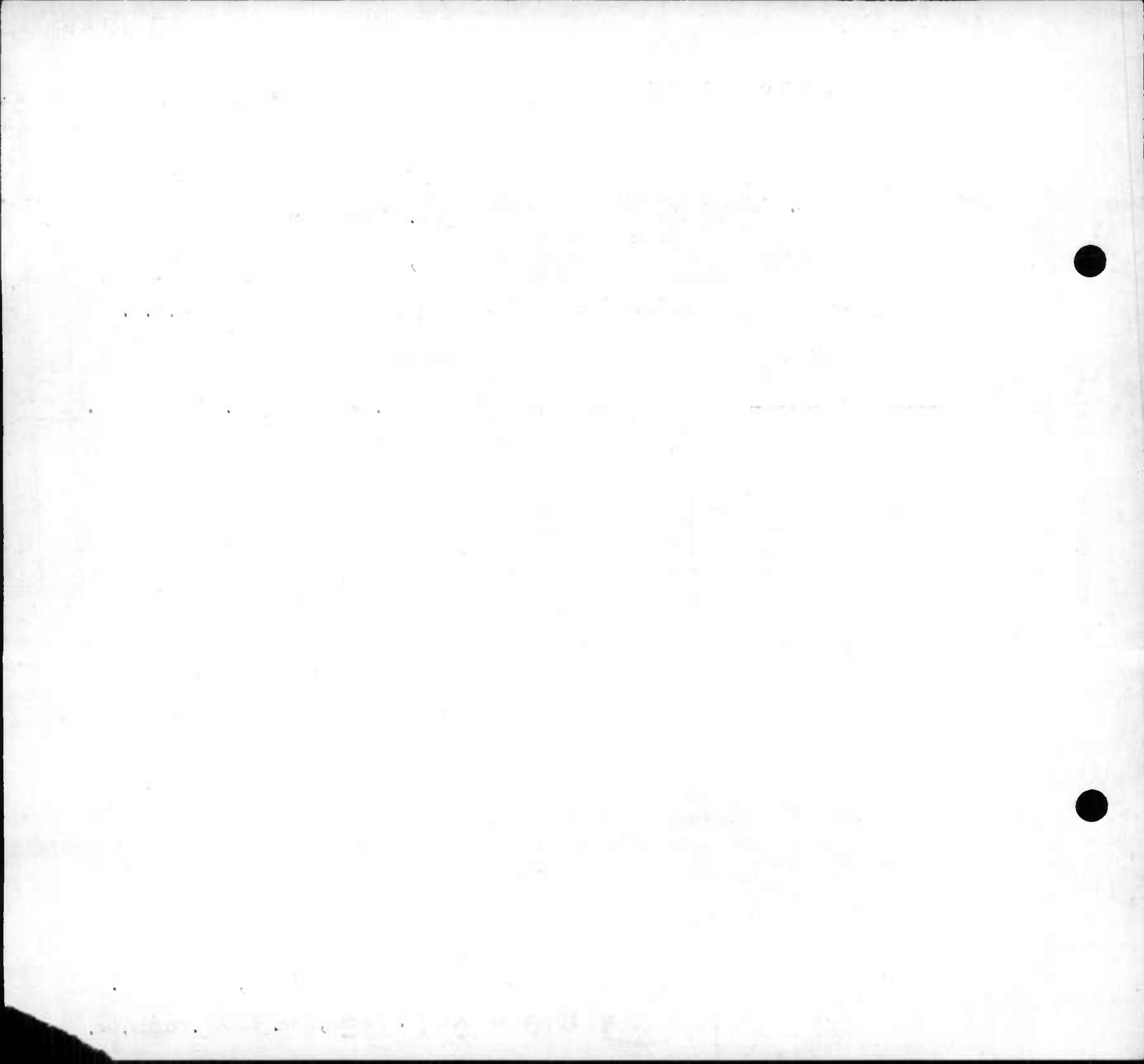
P-200		69 12207		BALTIMORE CITY HEALTH DEPARTMENT		X		69 12207	
BIRTH NO.		69-22351		CERTIFICATE OF DEATH		REG. NO.			
1. NAME OF DECEASED (Type or Print) BABY GIRL PUGH				2. DATE AND HOUR OF DEATH 12-8-69 8:50 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MARYLAND GENERAL HOSPITAL 18 Maryland General Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 6908 Broening Rd.					
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-8-69		9. AGE (In years last birthday) 20		10. If Under 1 Yr. Months Days 35	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James L. Pugh				14. MOTHER'S MAIDEN NAME Carol Ann Paul					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT 6908 Broening Road Mr. James L. Pugh, Dundalk, Md. 21222			
18. 276.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: Prematurity (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12:15 AM, 12-8-1969 to 8:50 PM, 12-8-1969 that (I) (we) last saw the deceased alive on 12-8-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE U. Sangkum				23B. DATE SIGNED 12-8-69		23C. PHYSICIAN'S NAME (Type) U. SANGKUM			
23D. ADDRESS Maryland General Hospital, Balto. Md.				23E. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

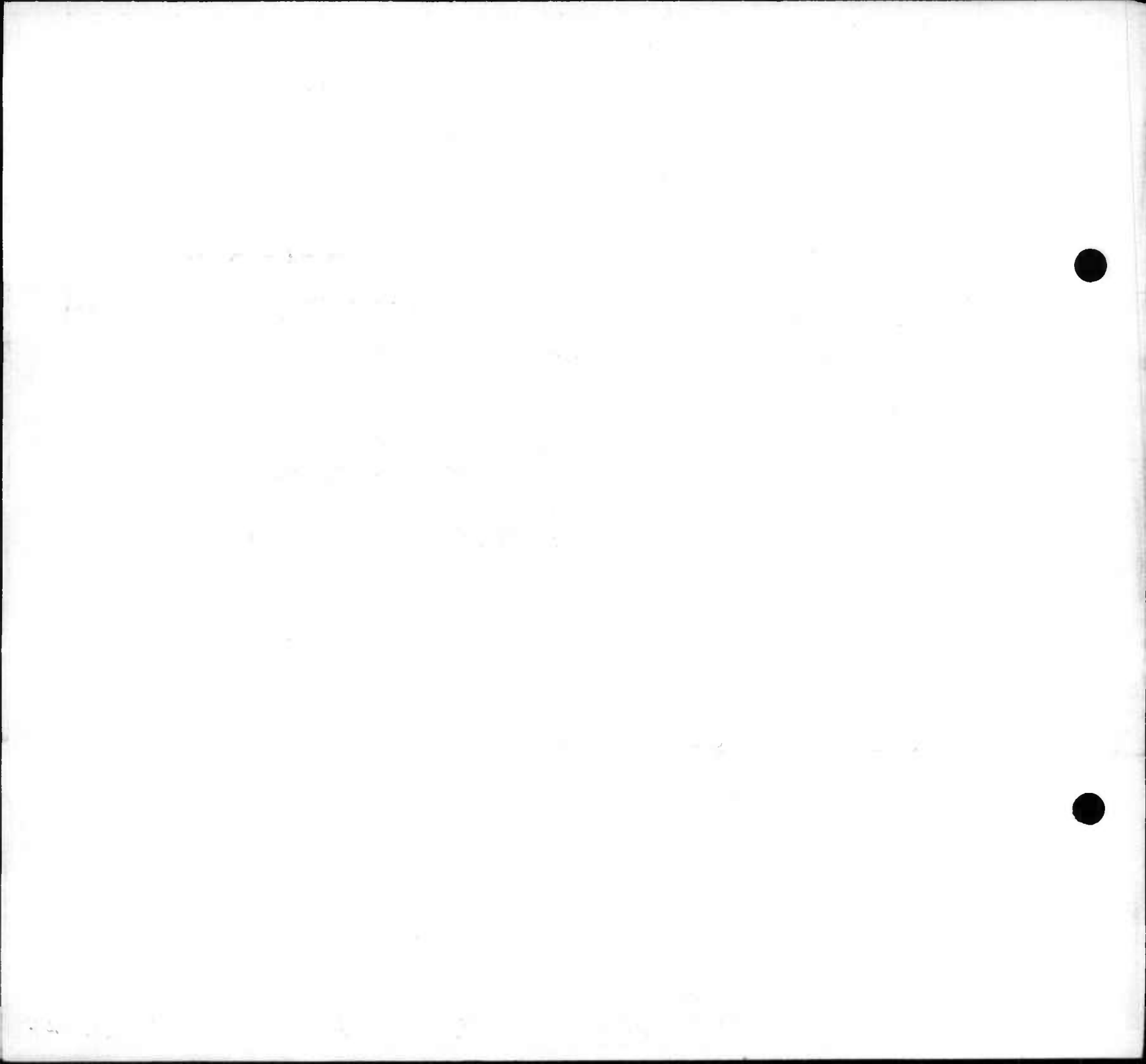
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12208
E-634		69 12208		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Geheviere Virginia Ertel		
2. DATE AND HOUR OF DEATH December 5, 1969		8 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 601		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 443 N. Linwood Avenue		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH May 22, 1901		9. AGE (In years last birthday) 68		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frank Smith		
14. MOTHER'S MAIDEN NAME unknown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) -----		
16. SOCIAL SECURITY NO. unknown		17. INFORMANT Joseph C. Ertel 443 N. Linwood Ave.		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) adenocarcinoma of right breast, general carcinomatous, acute left pulmonary embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mos 4 hrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Feb 8 19 69 to December 5 19 69 , that (I) (we) last saw the deceased alive on December 5 19 69 and that in (my) (last) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.				
23A. SIGNATURE L.C. Dobihal		23B. DATE SIGNED 12/8/69		23C. PHYSICIAN'S NAME (Type) L.C. Dobihal, M.D.
23D. ADDRESS 447 N. Kenwood Ave Balto Md 24		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 12/9/69		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR John A. Moran, Inc.		25C. FUNERAL DIRECTOR ADDRESS 3000 E. Balto. St.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

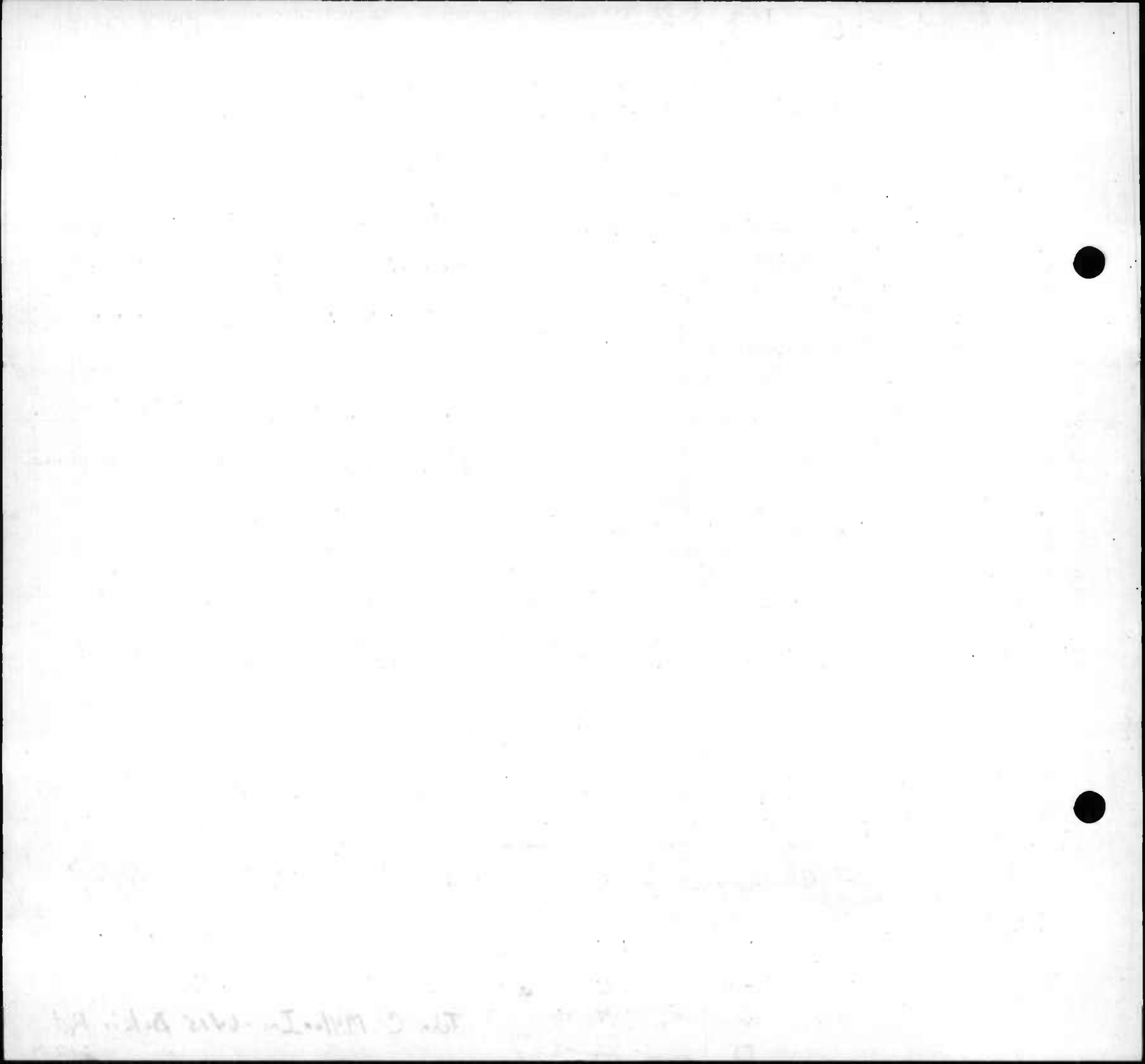
M-624		69 12209		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12209	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) Marshall, Georgia L.				2. DATE AND HOUR OF DEATH 12-7-69 12:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2735			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital 48				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4008 Overlea Ave.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-16-90	9. AGE (In years last birthday) 80 79	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) North Carolina Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Alphonsus Stokes				14. MOTHER'S MAIDEN NAME Burke, Catherine			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-07-9060		17. INFORMANT Franklin Square Hospital	
18. 4/12/31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ISCHEMIC HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). permission by telegram.							
19A. DATE OF OPERATION 2-		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/22/69 to 12/7/69 that (I) (we) lost saw the deceased alive on 12/7/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael G. [Signature]				23B. DATE SIGNED 12/7/69		23C. PHYSICIAN'S NAME (Type) [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-10-69		24C. NAME of CEMETERY or CREMATORY New Cathedral Cem.	
24D. LOCATION Baltimore Md.				25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.				25C. FUNERAL DIRECTOR J. M. [Signature]			
25D. ADDRESS 00 [Signature]				25E. ADDRESS J. M. [Signature] Inc-6415 Belair Rd.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

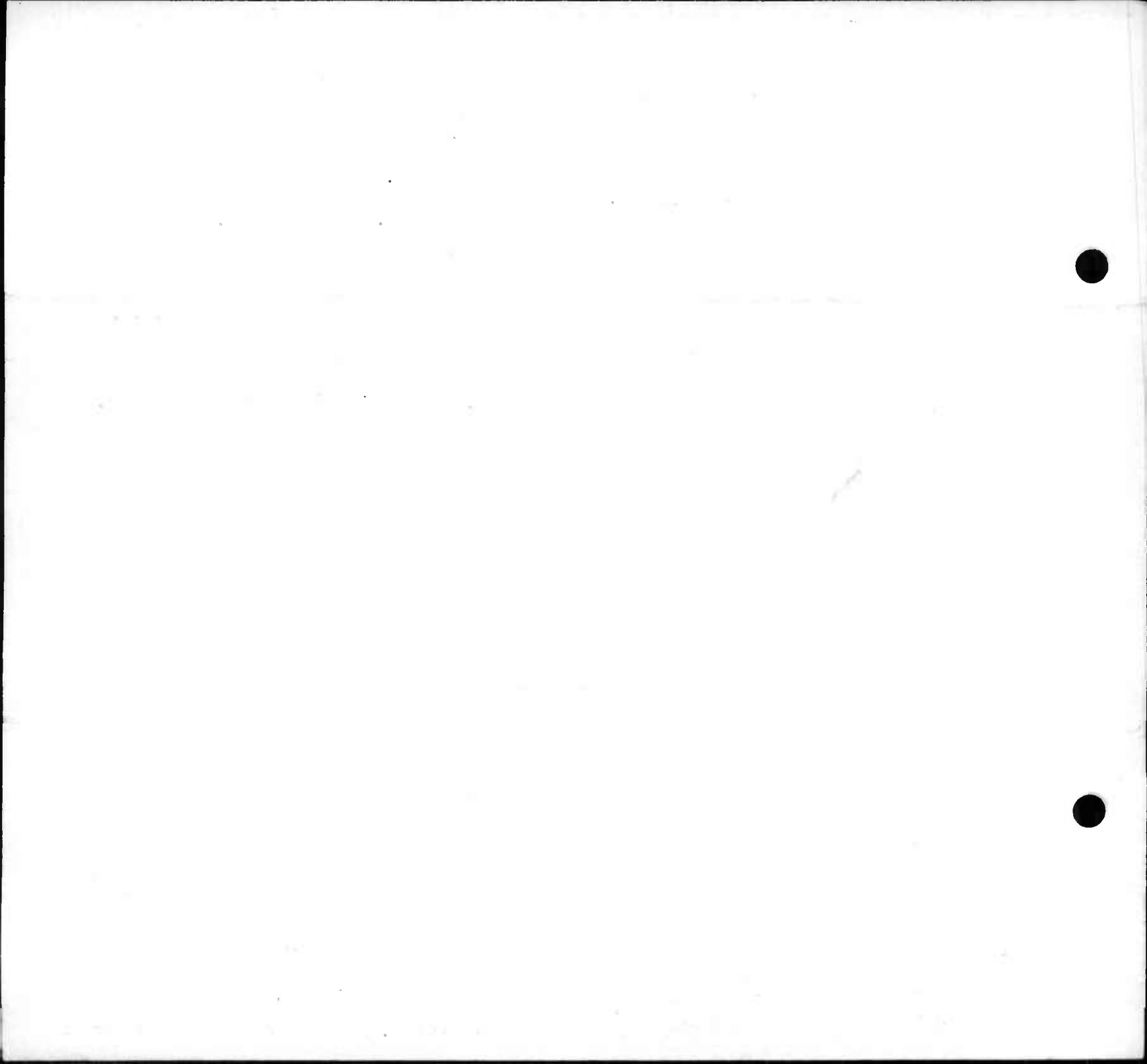
J-525		69 12210		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12210	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Margaret Estelle Jamison</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH <i>December 6, 1969</i> <i>9 A.</i> M.			
FULL NAME OF HOSPITAL OR INSTITUTION <i>00 6214 Walther Avenue</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2744</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>6214 Walther Avenue - 21206</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 18, 1894</i>	9. AGE (In years lost birthday) <i>75</i>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>John Saffran</i>			14. MOTHER'S MAIDEN NAME <i>Mary Imvold</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Beryl K. Simolunas - 6214 Walther Ave.</i>		
18. <i>492X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Pulmonary Emphysema</i> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Sept 22</i> <i>1956</i> to <i>December 6</i> <i>1969</i> , that (I) (we) last saw the deceased alive on <i>December 6</i> <i>1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Edward J. Alessi M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/8/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>EDWARD J. ALESSI M.D.</i>				23D. ADDRESS <i>6217 Harford Road Balto. Md. 21214</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-9-69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 10 1969</i>		25B. NAME OF REGISTRAR <i>John C. Miller, Inc.</i>		25C. FUNERAL DIRECTOR <i>John C. Miller, Inc. - 6415 Belair Rd.</i>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

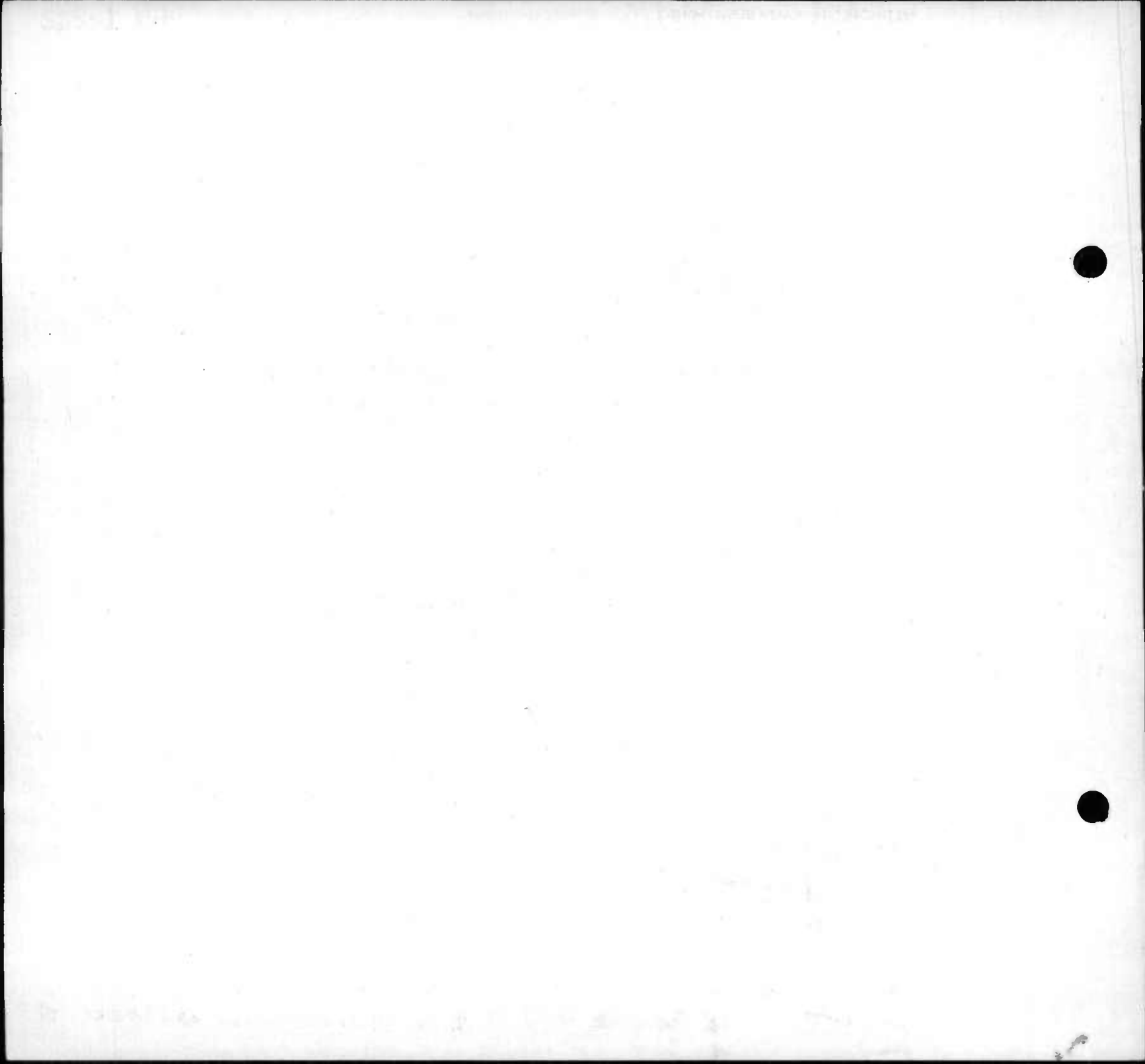
S-352		BALTIMORE CITY HEALTH DEPARTMENT		69 12211		REG. NO. 69 12211	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Leo Staniewicz (Stanley)		2. DATE AND HOUR OF DEATH 12/4/69 9:25 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 203		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital, Inc.		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 502 S. Washington St.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/26/09	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Riviter		10B. KIND OF BUSINESS OR INDUSTRY Boeing		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter Staniewicz		14. MOTHER'S MAIDEN NAME Helen Matega		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Lee Stanley jr		ADDRESS 2909 Chenook Ave.	
<p>18. 1621 I</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE Pulmonary Embolism DUE TO, OR AS A CONSEQUENCE OF:					
		(B) Adenocarcinoma of the Lung DUE TO, OR AS A CONSEQUENCE OF:					
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		Metastatic Brain syndrome					
		19A. DATE OF OPERATION 12/3/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED THORACIC FLUIDAL EFFUSION		20A. AUTOPSY? (Yes or No) NO	
		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month (Day) (Year) (Hour) (Approx.))		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 10/21/69 to 12/14/69 that (I) (we) last saw the deceased alive on 12/4/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert J. Rosenstock		23B. DATE SIGNED 12/4/69		23C. PHYSICIAN'S NAME (Type) Robert J. Rosenstock		23D. ADDRESS MERCY HOSP.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/6/1969		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Tashy, M.D.		25C. FUNERAL DIRECTOR Raymond L. Sazcorowski		ADDRESS 2525 Fleet Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-650		69 12212		BALTIMORE CITY HEALTH DEPARTMENT		69 12212	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) CARRIE L. GREENE				2. DATE AND HOUR OF DEATH 12-05 am 12/8/69			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital				A. STATE Maryland		B. COUNTY 1506	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1619 St. Stephen's St.			
5. SEX Female	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-14-18	9. AGE (In years last birthday) 51	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ALBERTUS DOUGHTY			14. MOTHER'S MAIDEN NAME DAISEY LAWSON				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 219-01-0399		17. INFORMANT Rosecoe Greene same as above		ADDRESS
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Malignant eschexie wide spread metastasis (B) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma breast (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/11/69 to 12/8/69 and that (I) (we) last saw the deceased alive on 12-05 am 12/8/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Rosecoe Greene M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/8/69	
23C. PHYSICIAN'S NAME (Type) PRATIMA KHASTAGIR				23D. ADDRESS Lutheran Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-11-69		24C. NAME OF CEMETERY or CREMATORY BALTIMORE NATIONAL		24D. LOCATION (City, town, or county) (State) BALTIMORE, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR CHARLES A. RICE			
				ADDRESS 661 W. PARK ST.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12213	
C-145 69 12213					
CERTIFICATE OF DEATH					
BIRTH NO.		1. NAME OF DECEASED JAMES ACROOM (OR) JAMES COPELAND		2. DATE AND HOUR OF DEATH 12-8-69 7:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIVERSITY OF MARYLAND HOSP.			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 748 REDWOOD ST.		
5. SEX Male	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-1900	9. AGE (In years last birthday) 69	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UK		10B. KIND OF BUSINESS OR INDUSTRY UK		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME James Copeland			
14. MOTHER'S MAIDEN NAME Oliver		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO.		17. INFORMANT Mamie Copeland 748 Redwood St			
18. 582X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE Chronic renal failure UK DUE TO, OR AS A CONSEQUENCE OF: (B) Chronic renal disease UK DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If In Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-5 19 69 to 12-8 19 69 , that (I) (we) last saw the deceased alive on 12-8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael G. Hayes, M.D.				23B. DATE SIGNED 12-8-69	
23C. PHYSICIAN'S NAME (Type) Michael G. Hayes, M.D.				23D. ADDRESS Univ. of Md. H&P.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/69		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION (City, town, or county) Baltimore		24E. (State) MD		25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969	
25B. NAME OF REGISTRAR Robert E. Fairley		25C. FUNERAL DIRECTOR Glenn R. Pace 661 W. Barre St			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p style="font-size: 24pt; margin: 0;">G-342</p> <p style="font-size: 24pt; margin: 0;">69 12214</p>		<p style="font-size: 24pt; margin: 0;">69 12214</p>	
<p style="font-size: 18pt; margin: 0;">BIRTH NO.</p>		<p style="font-size: 18pt; margin: 0;">REG. NO.</p>	
<p>1. NAME OF DECEASED (Type or Print) JOSEPH WALTER GODLESKI</p>		<p>2. DATE AND HOUR OF DEATH 12-6-69 8:40 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Balt. Gen Hosp 43</p>		<p>A. STATE Maryland B. COUNTY 2401</p>	
<p>5. SEX Male</p>		<p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>6. RACE white</p>		<p>E. STREET AND NUMBER 1406 Hull street</p>	
<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH 1927 7-11-24 9. AGE (In years last birthday) 42</p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance man</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY General Electric</p>	
<p>11. BIRTHPLACE (State or foreign country) Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME JOSEPH GODLESKI</p>		<p>14. MOTHER'S MAIDEN NAME Catherine Forster</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 3-1-45 thru 7-15-46</p>		<p>16. SOCIAL SECURITY NO. 217-22-3826</p>	
<p>17. INFORMANT Mrs. Madeline Godleski</p>		<p>ADDRESS 2807 Eastern Ave.</p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death) DIABETES MELLITUS Cerebral injury Hypoglycemia</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 69 69 69</p>	
<p>19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II</p>		<p>20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CHIEF OF MEDICAL EXAMINER</p>	
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (H) (this hospital) attended the deceased from 8:15 PM 12-4-69 to 8:40 PM 12-6-69, that (H) (we) last saw the deceased alive on 8:40 PM 12-6-19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Henry Citen</p>		<p>23B. DATE SIGNED 12-6-69</p>	
<p>23C. PHYSICIAN'S NAME (Type) HENRY CITEN</p>		<p>23D. ADDRESS 3001 S. Hanover street Balt MD</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 12/11/69</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY ST. Stanislaus Cemetery</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 10 1969</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor</p>	
<p>25C. FUNERAL DIRECTOR Stevens Funeral Home, Inc.</p>		<p>ADDRESS 9501 E. Fort Avenue</p>	

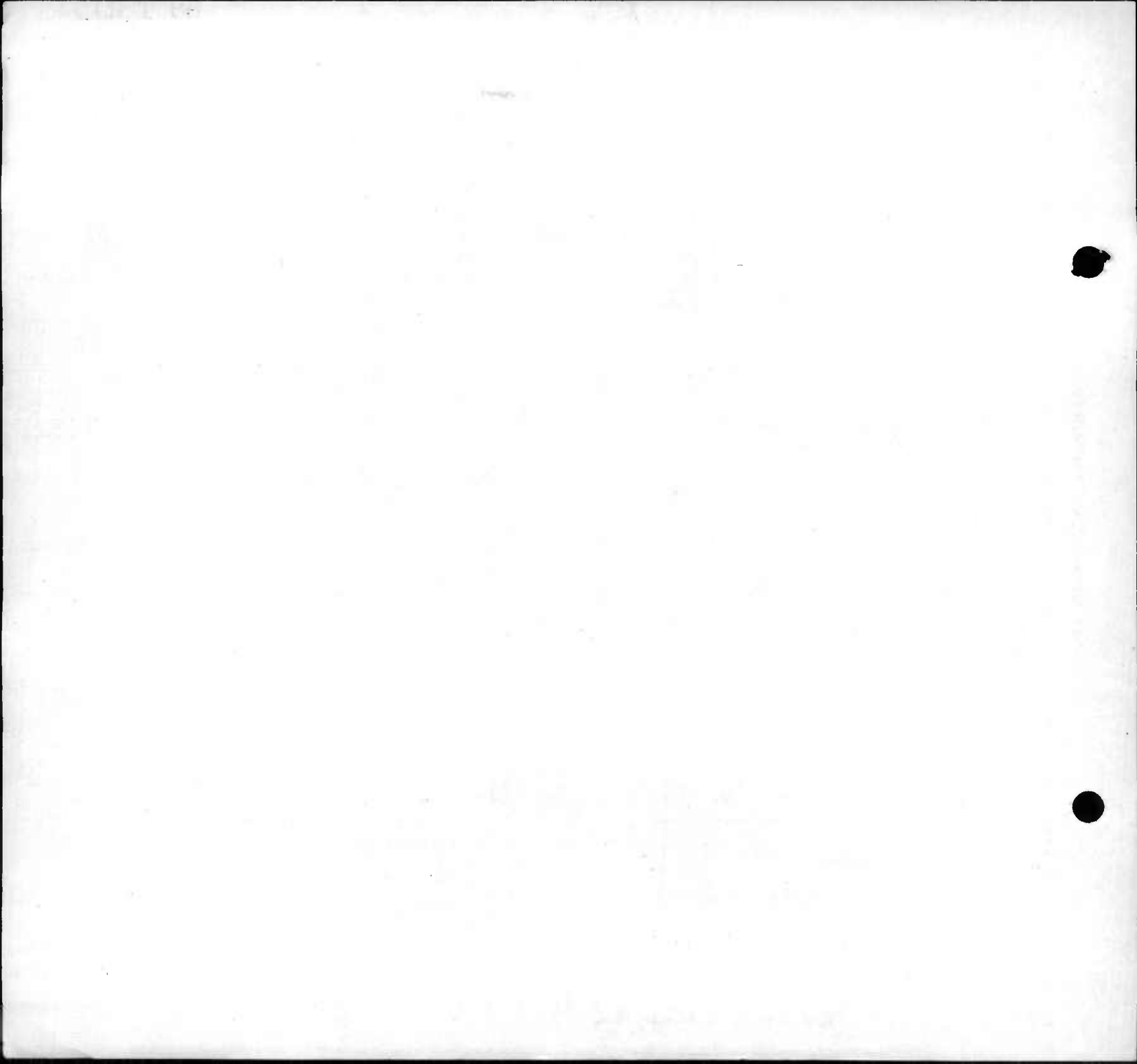
12/11/69 - Correction form from funeral director.

A.B.C.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

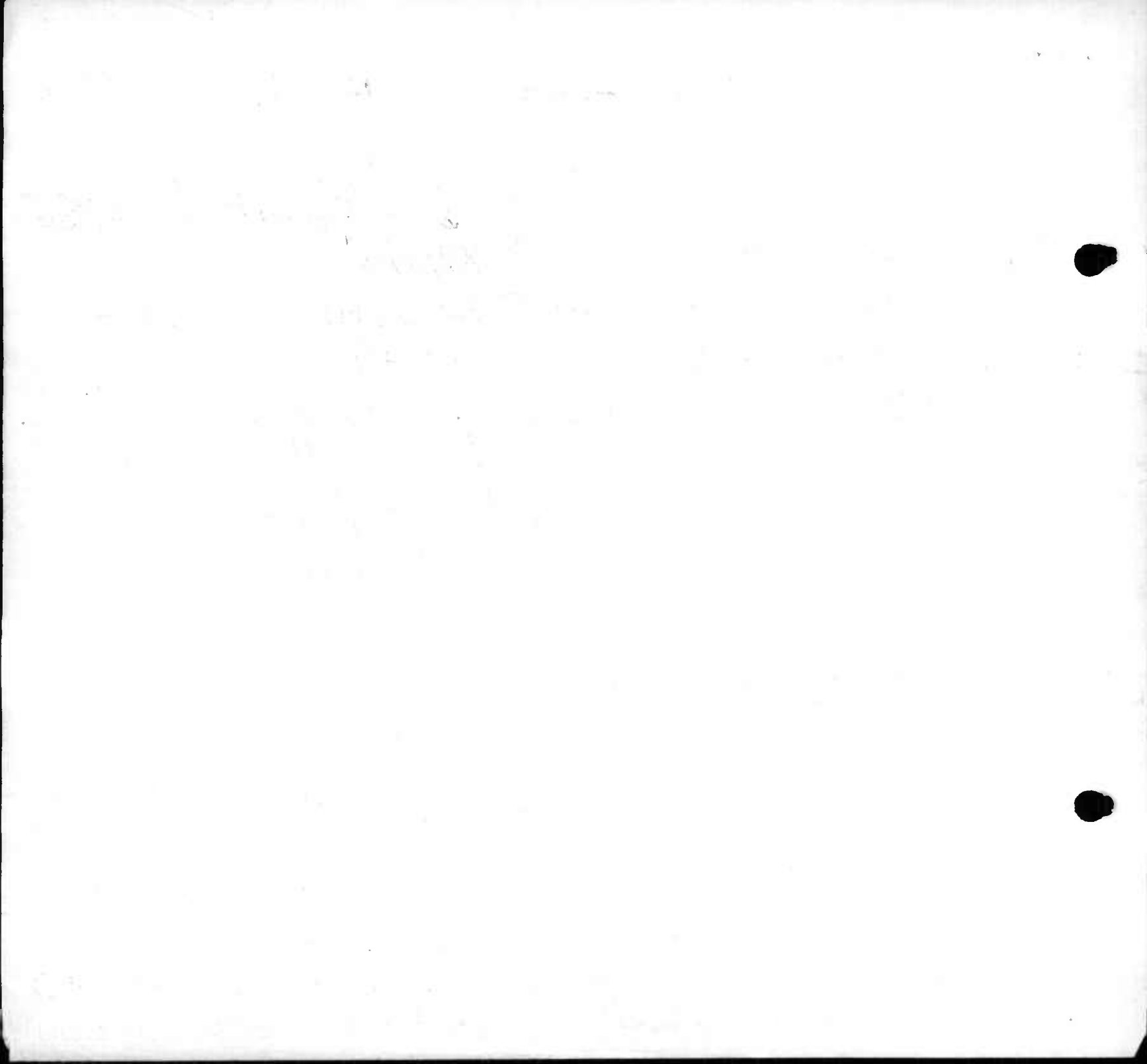
C-355		69 12215		BALTIMORE CITY HEALTH DEPARTMENT		69 12215		REG. NO.						
BIRTH NO.					1. NAME OF DECEASED (Type or Print) <i>Andrew J. Chatman</i>					2. DATE AND HOUR OF DEATH <i>12-8-69</i> <i>9:00 P.M.</i>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>1403</i>				
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>					(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>2009 Druid Hill Ave.</i>					C. CITY OR TOWN <i>Balto.</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER <i>2009 Druid Hill Ave.</i>					5. SEX <i>Male</i> 6. RACE <i>Negroid</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <i>11/22/00</i> 9. AGE (In years lost birthday) <i>69</i>				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Caterer</i>					10B. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (State or foreign country) <i>Virginia</i>				
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					13. FATHER'S NAME <i>William Chatman</i>					14. MOTHER'S MAIDEN NAME <i>Maggie Crawley</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. <i>212-18-3891</i>					17. INFORMANT <i>Alma Chatman</i> ADDRESS <i>Same</i>				
18. <i>185X I</i> CAUSE OF DEATH										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Carcinoma of Prostate</i> <i>3 years</i>				
(B) DUE TO, OR AS A CONSEQUENCE OF:										(C) DUE TO, OR AS A CONSEQUENCE OF:				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).														
19A. DATE OF OPERATION <i>N/A</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>No</i>				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>N/A</i>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>N/A</i>				
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>N/A</i>					21D. TIME OF INJURY (APPROX.) <i>N/A</i>					21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>				
21F. HOW DID INJURY OCCUR? <i>N/A</i>					22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 69</i> 19 to <i>Dec</i> 1969, that (I) (we) last saw the deceased alive on <i>Dec 3</i> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Ralph M. Howard M.D.</i>										23B. DATE SIGNED <i>12-9-69</i>				
23C. PHYSICIAN'S NAME (Type) <i>Ralph M. Howard M.D.</i>					23D. ADDRESS <i>1230 Druid Hill Balto. Md 21217</i>									
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>12-12-69</i>					24C. NAME OF CEMETERY OR CREMATORY <i>Arboretum Mem. Pk.</i>				
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					25A. DATE REC'D BY HEALTH DEPT. <i>DEC 11 1969</i>					25B. NAME OF REGISTRAR <i>Ralph E. Bailey M.D.</i>				
25C. FUNERAL DIRECTOR <i>Robert F. A. Bailey</i>					ADDRESS <i>1348 Calhoun St.</i>									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

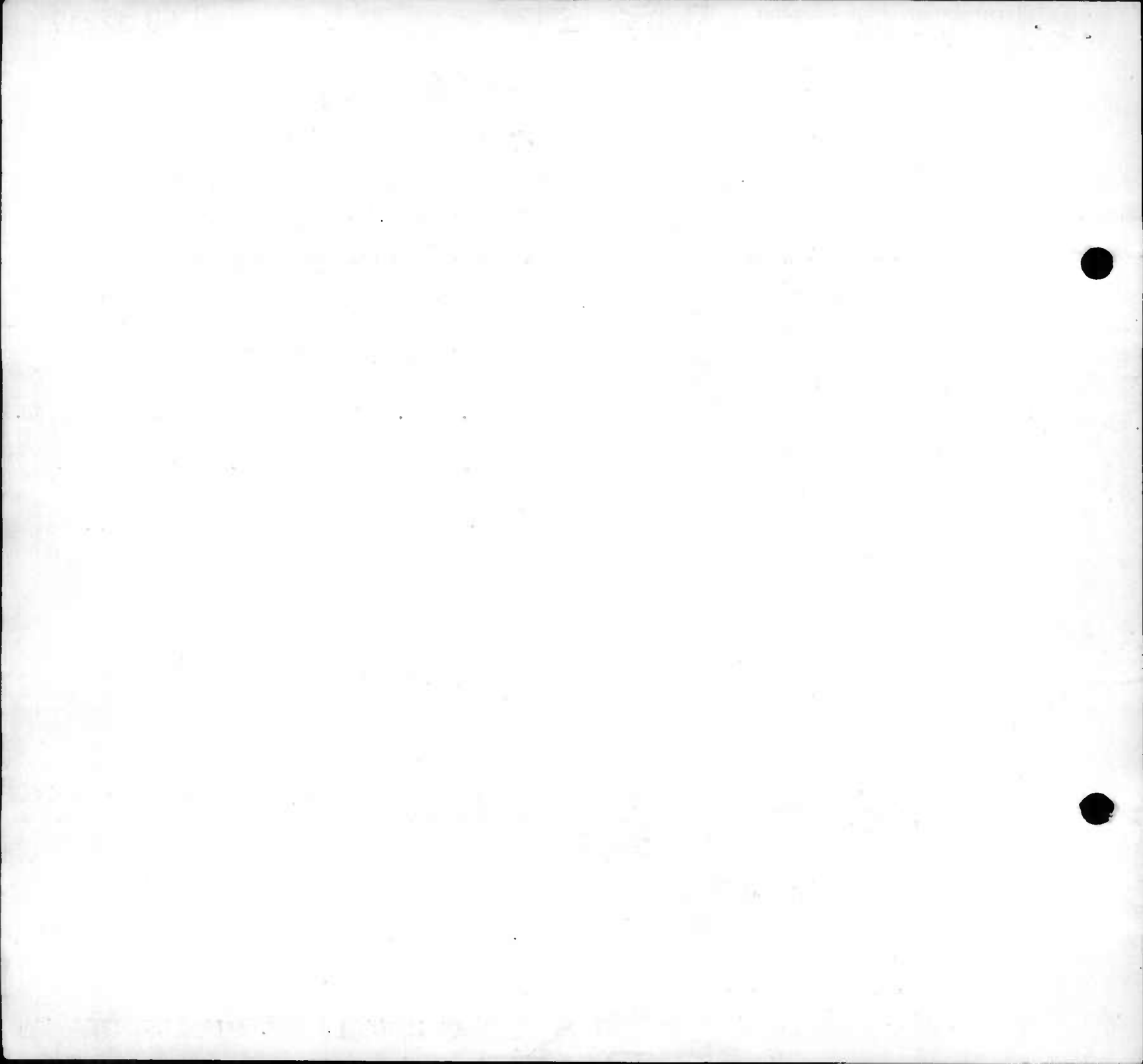
BALTIMORE CITY HEALTH DEPARTMENT				69 12216		69 12216	
CERTIFICATE OF DEATH				REG. NO.		69 12216	
BIRTH NO. L-600				69 12216		69 12216	
1. NAME OF DECEASED (Type or Print) <i>Jacob Lurie</i>				2. DATE AND HOUR OF DEATH <i>12.8.69 11:37 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>2831</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>H2S-1 N A 1 HOSPITAL</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>MALE</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-15-04</i> 9. AGE (in years last birthday) <i>65</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerk</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>FRUIT MARKET</i>		11. BIRTHPLACE (State or foreign country) <i>BALTO., MD.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>MAX LURIE</i>				14. MOTHER'S MAIDEN NAME <i>IDA?</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>218-09-1382</i>		17. INFORMANT <i>MRS. RITA GOLDSCHIEDER, 2442 FOREST GREEN RD.</i>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>Ca Left Kidney</i>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Ca Left Kidney</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Renal Failure</i>				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Heart Failure</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>11.27.69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Ca Left Kidney + Colon</i>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12.7.69</i> to <i>12.8.69</i> that (I) (we) last saw the deceased alive on <i>12.8.69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Roger Theodore M.D.</i>				23B. DATE SIGNED <i>12.8.69</i>			
23C. PHYSICIAN'S NAME (Type) <i>ROGER THEODORE M.D.</i>		23D. ADDRESS <i>Simon Hospital</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12.9.69</i>		24C. NAME of CEMETERY or CREMATORY <i>ANSHE EMUNAH</i>		24D. LOCATION (City, town, or county) (State) <i>WASH. BLVD. MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 11 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher, Md.</i>		25C. FUNERAL DIRECTOR <i>581 LEVINSON & BROS.</i>		25D. ADDRESS <i>6018 Reisterstown Rd.</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12217	
L-100 69 12217		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Isidore Herman LEVY		2. DATE AND HOUR OF DEATH 12-8-69 9:40 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LEVINDALE HEBREW HOME & INF. 91		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3802 Collier Road	
5. SEX MALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10B. KIND OF BUSINESS OR INDUSTRY Proprietor	9. AGE (In years last birthday) 77
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AARON Z. Levy		14. MOTHER'S MAIDEN NAME SARAH ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT MRS. GERTRUDE FRIEDMAN, 3802 COLLIER RD.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.4 I Aspiration Pneumonia 1 day		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, ASCVD - severe CBS years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 9-15-1967 to 12-8-1969 , that (I) (we) last saw the deceased alive on 12-8-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ardaiz		23B. DATE SIGNED 12-8-1969	
23C. PHYSICIAN'S NAME (Type) Jose ARDAIZ MD		23D. ADDRESS Levindale Hebrew Home & Inf.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 12-9-69	24C. NAME OF CEMETERY OR CREMATORY PETACH TIKVAH, ROSEDALE	24D. LOCATION (City, town, or county) (State) MARYLAND
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR SOL LEVITSON & BROS. 6000 REISTERSTOWN ROAD



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-346		69 12218		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 12218	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) NATHAN ADLER				2. DATE AND HOUR OF DEATH 12/8/69 7 40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 2 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				E. STREET AND NUMBER 3207 WOODVALLEY DRIVE			
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/20/84		9. AGE (in years last birthday) 85		10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant				10B. KIND OF BUSINESS OR INDUSTRY Self Employed				11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service) No.			
16. SOCIAL SECURITY NO.				17. INFORMANT Schwartz Bros. 60 E. Tremont Ave.				18. ADDRESS 10453			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 412.4 + 195.0				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF Acute Pulmonary Edema (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 weeks			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Intestinal Obstruction				20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
19A. DATE OF OPERATION 11/7/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal Obstruction		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 11/6 19 69 to 12/8 19 69 that (I) (we) last saw the deceased alive on 12/8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Victor Borden MD				23B. DATE SIGNED 12/8/69				23C. PHYSICIAN'S NAME (Type) VICTOR BORDEN MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal & Burial				24B. DATE 12-10-69				24C. NAME of CEMETERY or CREMATORY Beth David Cemetery			
24D. LOCATION (City, town, or county) (State) Elmont L.I., N.Y.				25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			
25C. FUNERAL DIRECTOR Dr. Schwartz Bros. 60 E. Tremont Ave.				25D. ADDRESS 60 E. Tremont Ave.							

21st HOSPITAL

M W

BATTIMORE

EXCS MEDICAL

4/22/84 22

(Lent Palmer)
A2C VD

Int. Sec. 10/1/84

10/1/84 To the ...

10/1/84 11/1/84

Victor Borden MD
21st HOSPITAL

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		69 12219	
P-565		69 12219	
BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
Pomerantz SARAH		12/7/69 3:40 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE & COUNTY	
Sinai Hospital Inc.		Maryland	
5. SEX		6. RACE	
Female		White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
		7-23-01	
9. AGE (in years last birthday)		68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Housewife		at Home	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Russia		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Samuel Pressman		Jolyn Soubel	
15. Was Deceased Ever in U. S. Armed Forces? (Yes or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		866-14-66330	
17. INFORMANT		ADDRESS	
Mrs. Leon Lingross		3813 Glen Ave. #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.41		12 days	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:	
Bilatera Pneumonia		20 years	
Congestive Heart Failure		24 years	
Arterio Sclerotic Cardio Vasc. Disease		10 years	
Rheumatoid Arthritis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
0			
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21A. TIME OF INJURY (APPROX.)		21B. WHERE DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		(If in Baltimore City, give exact location)	
21C. HOW DID INJURY OCCUR?		21D. INJURY OCCURRED	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) lost saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
Carlos Perel		12/7/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
Sinai Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		12-8-69	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Baltimore Hebrew		Brynmawr Lane, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
DEC 11 1969		Sol Levinson	
25C. FUNERAL DIRECTOR		25D. ADDRESS	
Sol Levinson & Bros.		Reisters Town Rd	

March 1964
Baltimore
3813 Green Ave #1E
T/3/64

Green Hospital Inc
F W

Baltimore, Maryland

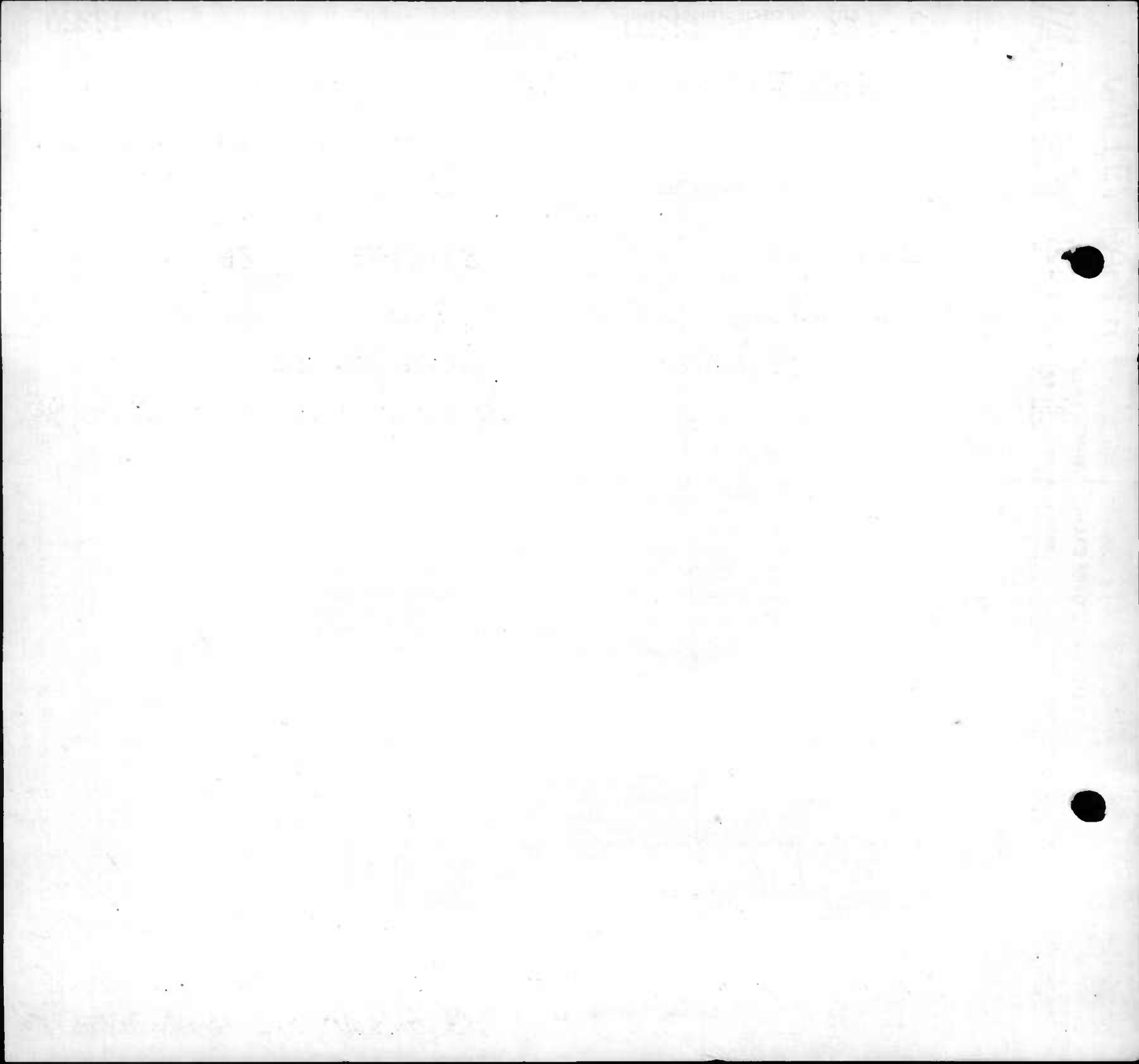
Longshore East Future
Hypertensive (high blood pressure) in a
Kleiman, 1964, 4-12-64

12/1/64
X
Green Hospital

Green
Green Hospital

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

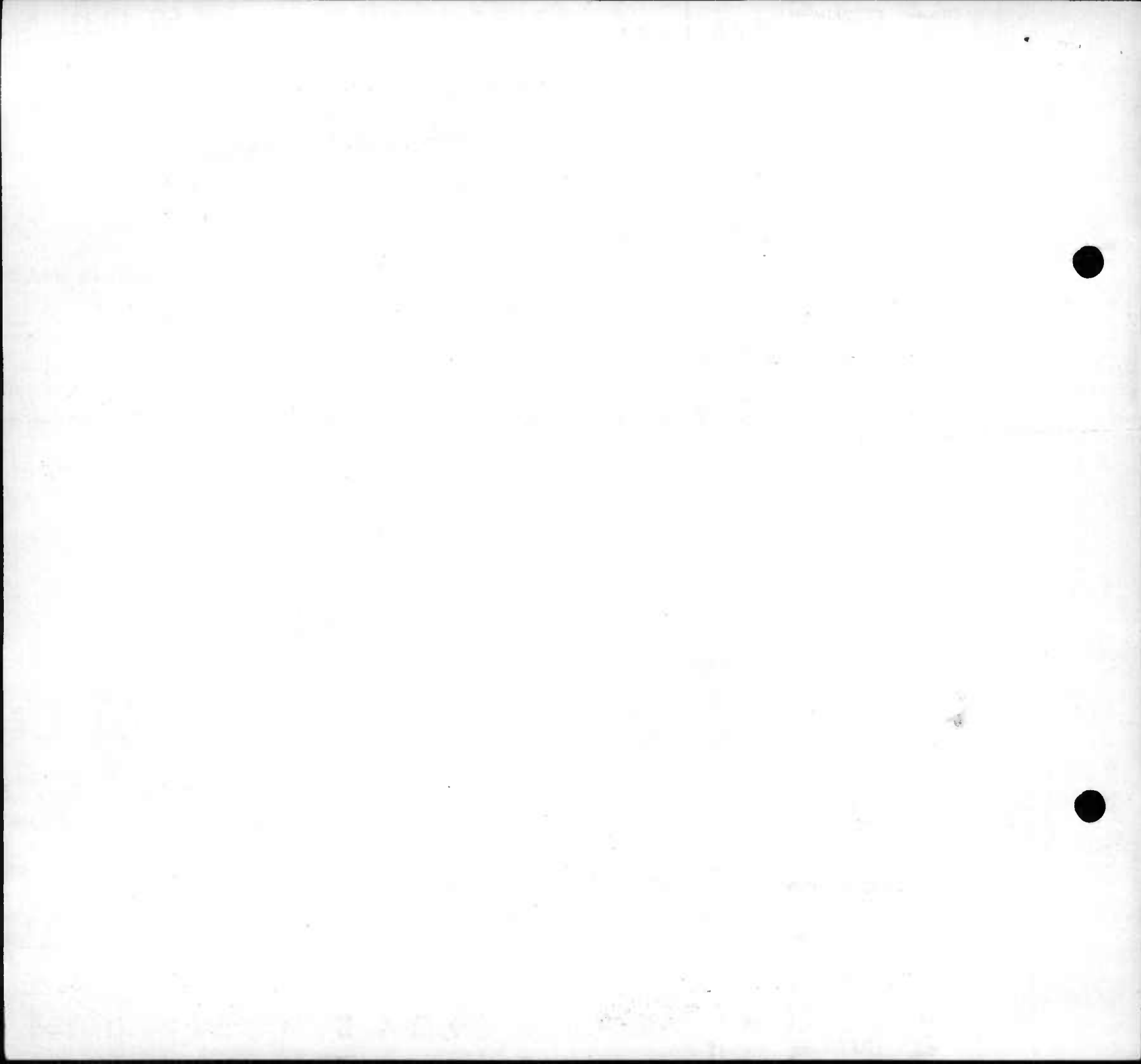
VS 150-REV. 1/1/6B



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

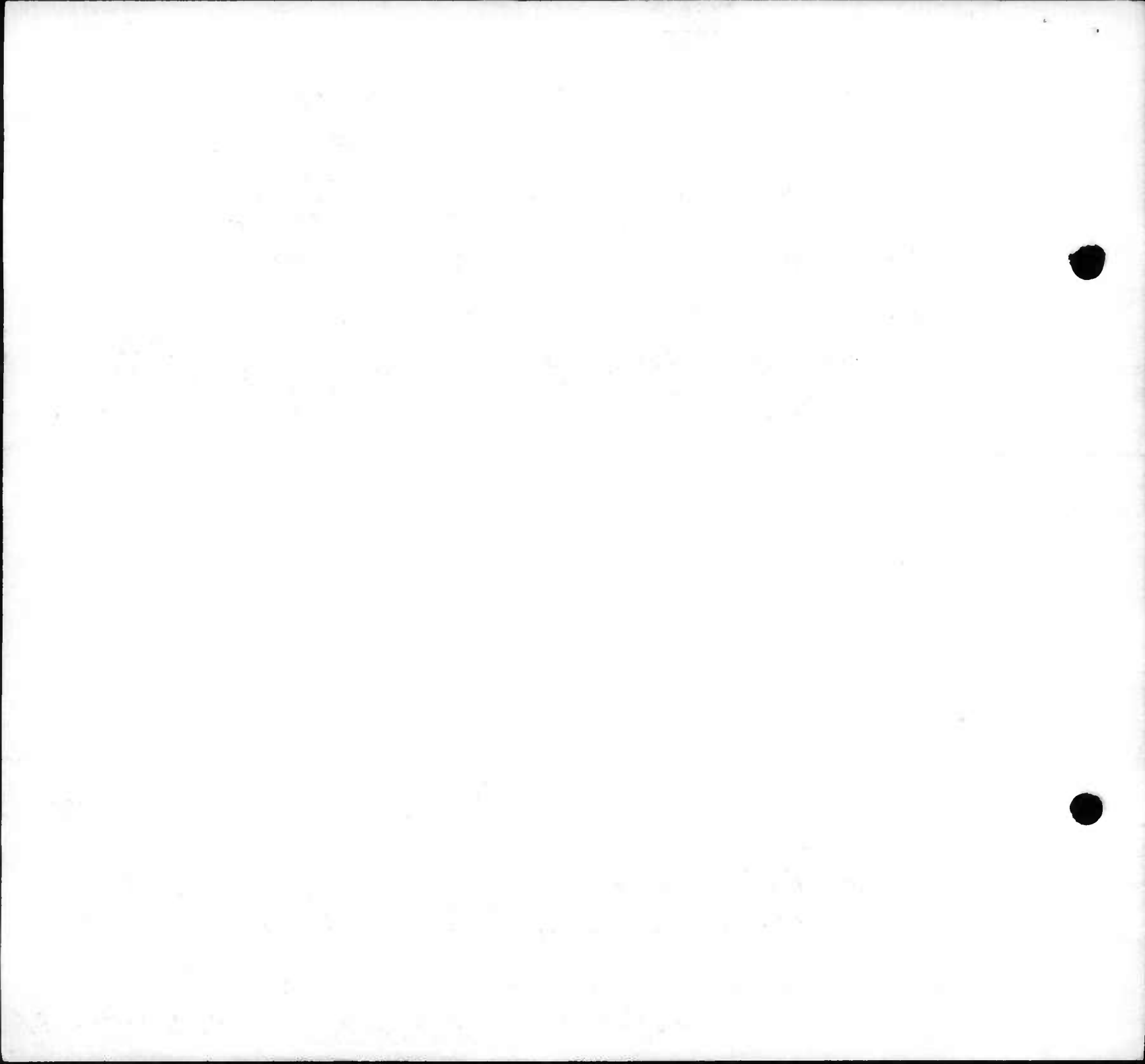
BALTIMORE CITY HEALTH DEPARTMENT				69 12221		REG. NO. 69 12221	
BIRTH NO. B-200		69 12221		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ABRAHAM BASS		2. DATE AND HOUR OF DEATH 12/6/69 5:30/A.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2740		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-12-95	
9. AGE (In years lost birthday) 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OSCAR BASS		14. MOTHER'S MAIDEN NAME HINDA ?		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI ARMY		16. SOCIAL SECURITY NO. 218-32-1461	
17. INFORMANT MRS. GERTRUDE BASS		ADDRESS 3508 MENLO DR. #1		18. CAUSE OF DEATH Ac. MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 HRS.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/5 19 69 to 12/6 19 69 , that (I) we last saw the deceased alive on 12/6 19 69 and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (I) we (did) not view the body after death.		23A. SIGNATURE Raymond F. Caplan, M.D.		23B. DATE SIGNED 12/6/69			
23C. PHYSICIAN'S NAME (Type) RAYMOND F. CAPLAN, M.D.		23D. ADDRESS 1010 ST. PAUL ST.		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-7-69	
24C. NAME OF CEMETERY OR CREMATORY Hebrew Young Men		24D. LOCATION (City, town, or county) (State) Windsor Mill Rd. MARYLAND		25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Dr. Lawrence E. Bue		ADDRESS 6010 Ruston Road					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

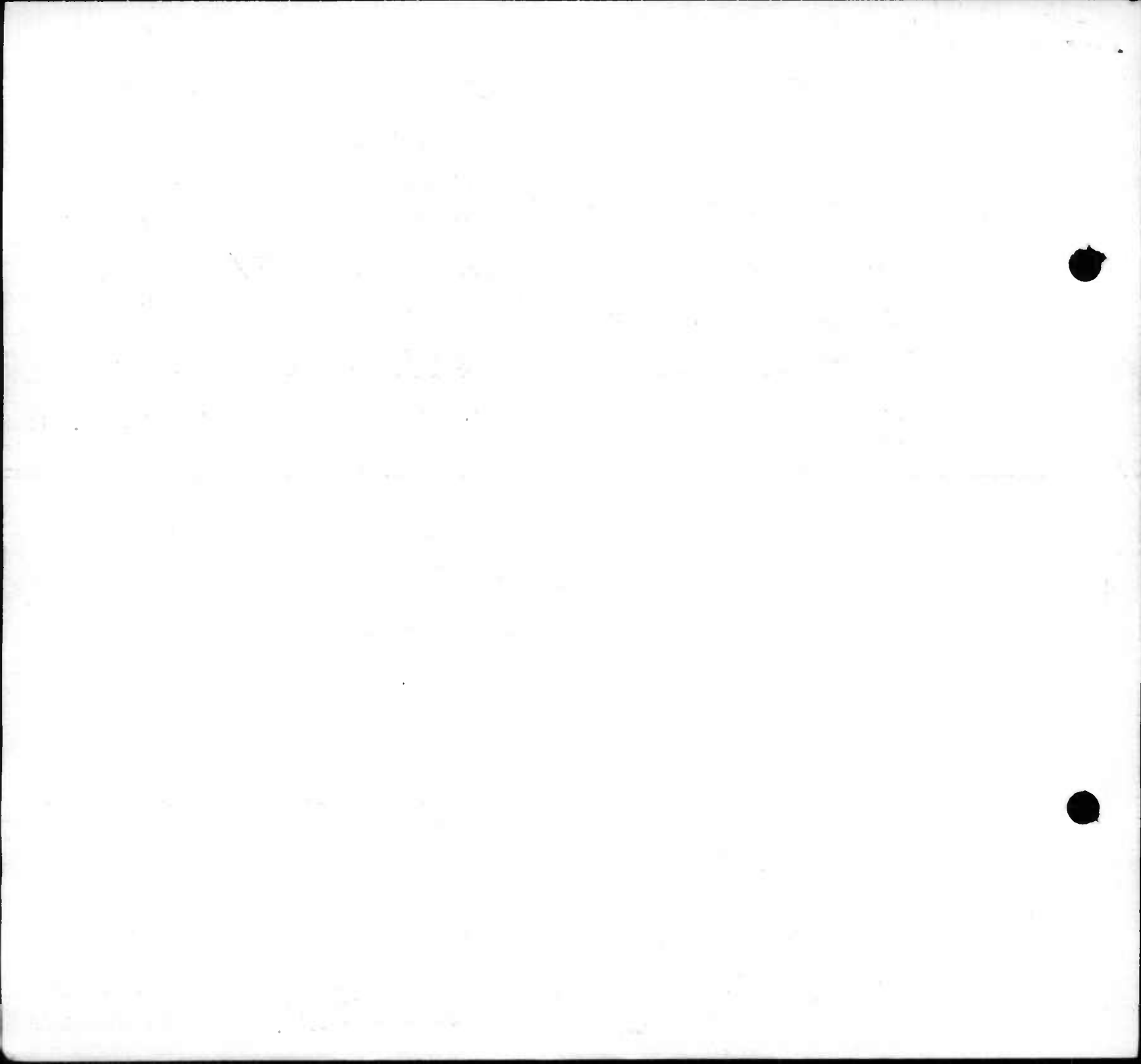
S-412		69 12222		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12222	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>SLOUSKY, NATHAN</i>				2. DATE AND HOUR OF DEATH <i>12/6/69</i> <i>4:00 P</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>2755</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>2 Senai Hospital of Baltimore</i>						C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Male</i> 6. RACE <i>White</i> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <i>12/25/18</i>		9. AGE (In years last birthday) <i>51</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Salesman</i>						10B. KIND OF BUSINESS OR INDUSTRY <i>Furniture</i>		11. BIRTHPLACE (State or foreign country) <i>Balto, Md</i>	
13. FATHER'S NAME <i>Albert Sloosky-Living</i>						14. MOTHER'S MAIDEN NAME <i>Sarah Chislow-Late</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>Yes WW2 Army</i>						16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Rose Sloosky</i> ADDRESS <i>Parents' home</i>	
18. <i>205.0 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Leukemia acute</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Myelogenous</i> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indicate medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <i>12/5</i> 19 <i>69</i> to <i>12/6</i> 19 <i>69</i> that (H) (we) lost saw the deceased alive on <i>12/6</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Rose F. Callicott</i>						23B. DATE SIGNED <i>12/6/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>ROSE F. CALICOTT</i>						23D. ADDRESS <i>Senai Hosp of Balto.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>12/7/69</i>		24C. NAME of CEMETERY or CREMATORY <i>Sharon Zion</i>		24D. LOCATION (City, town, or county) (State) <i>Balto, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 11 1969</i>		25B. NAME of REGISTRAR <i>Robert E. Bailey, M.D.</i>		25C. FUNERAL DIRECTOR <i>J.C. Brinson & Sons</i>		ADDRESS <i>6010 Register Street Rd.</i>			



FUNERAL DIRECTOR: IMPORTANT

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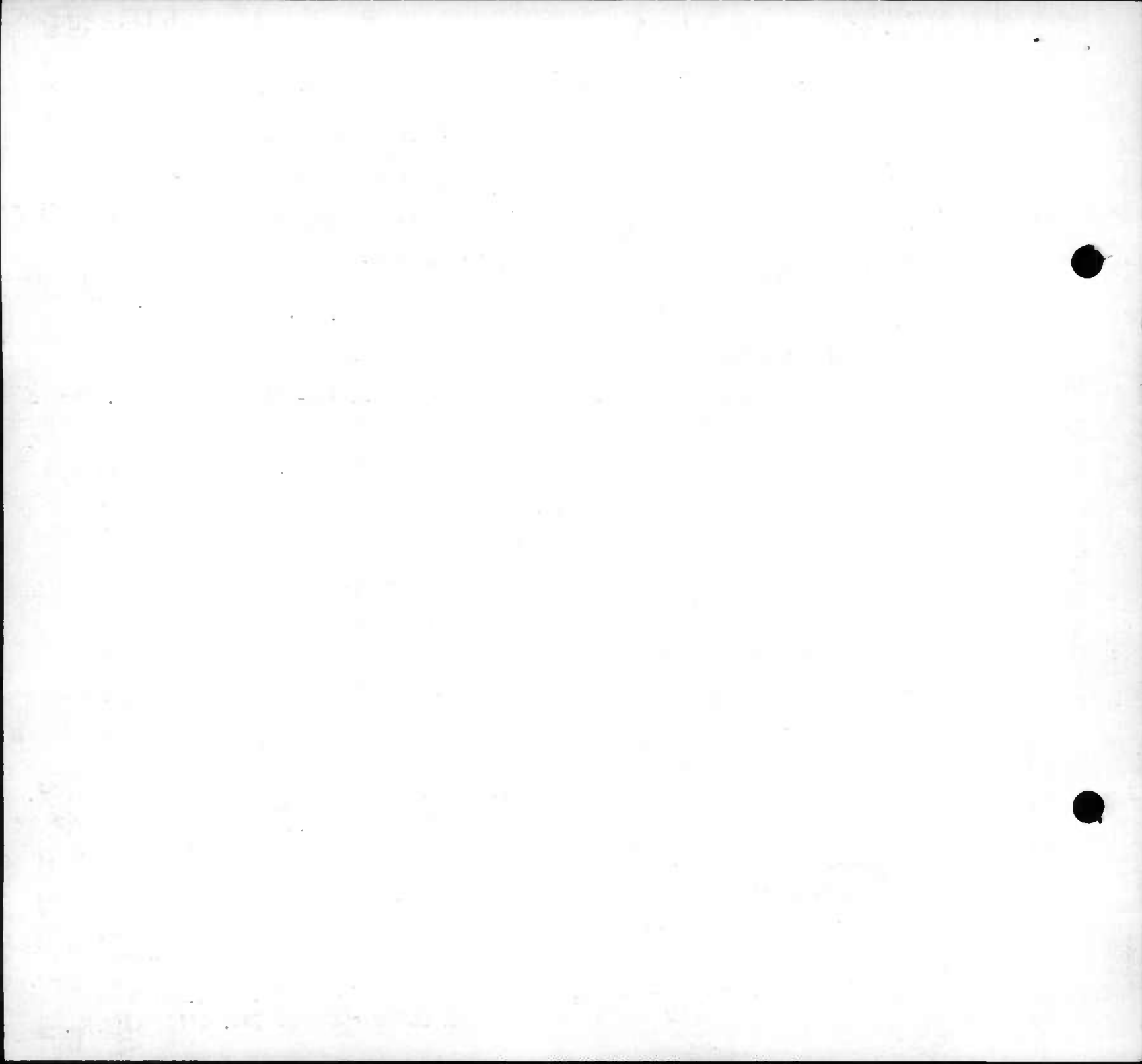
G-652		69 12223		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12223	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) GREENSTEIN BESSIE</p> </div> <div> <p>2. DATE AND HOUR OF DEATH 12-4-69 7.50 P.M.</p> </div> </div>							
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 12 SINAI HOSP. OF BALTO.</p>				<p>4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)</p> <p>A. STATE MARYLAND B. COUNTY 2841</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 4200 FERNHILL AVE #15</p>			
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH XXXXXX	9. AGE (in years last birthday) 77	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Weiner				14. MOTHER'S MAIDEN NAME BAILA WATERS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes or no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Frank Greenstein, 4200 Fernhill Ave. #15			
<p>18. 412.4 CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF: PULMONARY EMBOLIC(?)</p> <p>(B) C. H. F. DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C) A. S. C. V. D.</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<p>22. I certify that (I) (this hospital) attended the deceased from 12-4-1969 to 12-4-1969 that (I) (we) last saw the deceased alive on 12-4-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>							
23A. SIGNATURE H. Allen M.D.				23B. DATE SIGNED 12-4-69		23C. PHYSICIAN'S NAME (Type) CARLOS VALLEJO M.D.	
23D. ADDRESS SINAI HOSP. OF BALTO				23E. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD			
24A. BURIAL CREMATION, REAOVAL (Specify) Burial		24B. DATE 12-7-69		24C. NAME OF CEMETERY OR CREMATORY Hebrew Cemetery - Baltimore, Maryland		24D. LOCATION (City, town or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN ROAD			



FUNERAL DIRECTOR: IMPORTANT

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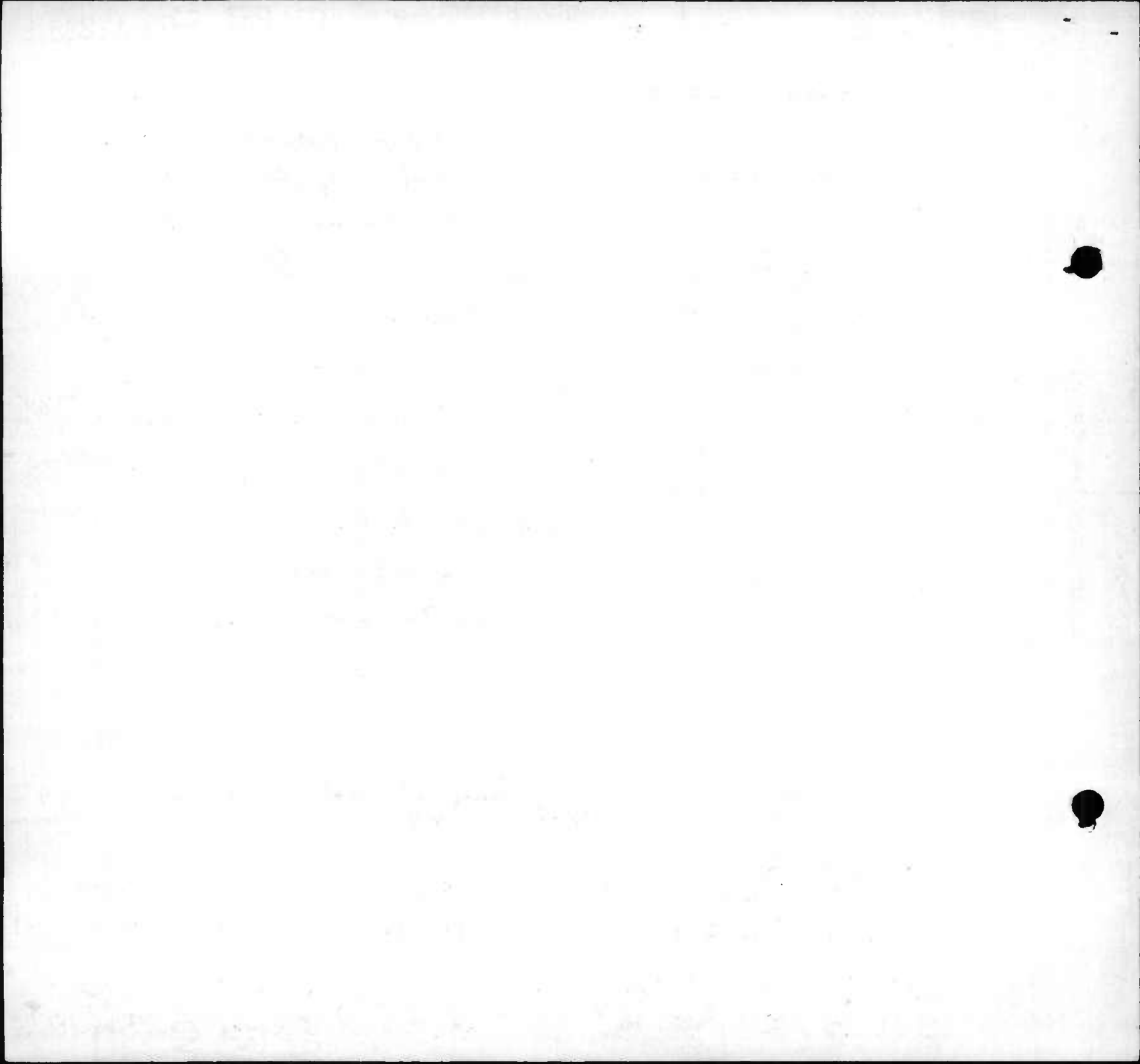
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12224	
S-160 69 12224		CERTIFICATE OF DEATH	
BIRTH NO.		DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) ALBERT J. SHAPIRO		12-6-69 10.42 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 425 Macai Hospital of Baltimore Inc		A. STATE MARYLAND B. COUNTY 2831	
		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4218 Labyrinth Rd #15	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-7-16
		9. AGE in years last birthday 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wholesale		10B. KIND OF BUSINESS OR INDUSTRY Jewelry	11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Louis Shapiro	
14. MOTHER'S MAIDEN NAME Anna Katz		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WW 2 Army	
16. SOCIAL SECURITY NO. 214-053335		17. INFORMANT Mrs Anne Shapiro-4218 Labyrinth Rd. #15	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) 410.9 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute myocardial infarction 3 days? (B) Arteriosclerotic Cardiovascular Disease 7 years (C) _____	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-12-68 1968 to 12/6 1969, that (I) (we) last saw the deceased alive on 12-6 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE H. Gerard Oster MD		23B. DATE SIGNED 12/6/69	
23C. PHYSICIAN'S NAME (Type) H. GERARD Oster MD		23D. ADDRESS 6821 Reisterstown Rd Bk 10	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/7/69	
24C. NAME OF CEMETERY OR CREMATORY Lubowitz Rosedale		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Fisher, MD	
25C. FUNERAL DIRECTOR SO LEVINSON & BROS INC.		ADDRESS 6010 Reist. Rd.	



FUNERAL DIRECTOR: IMPORTANT

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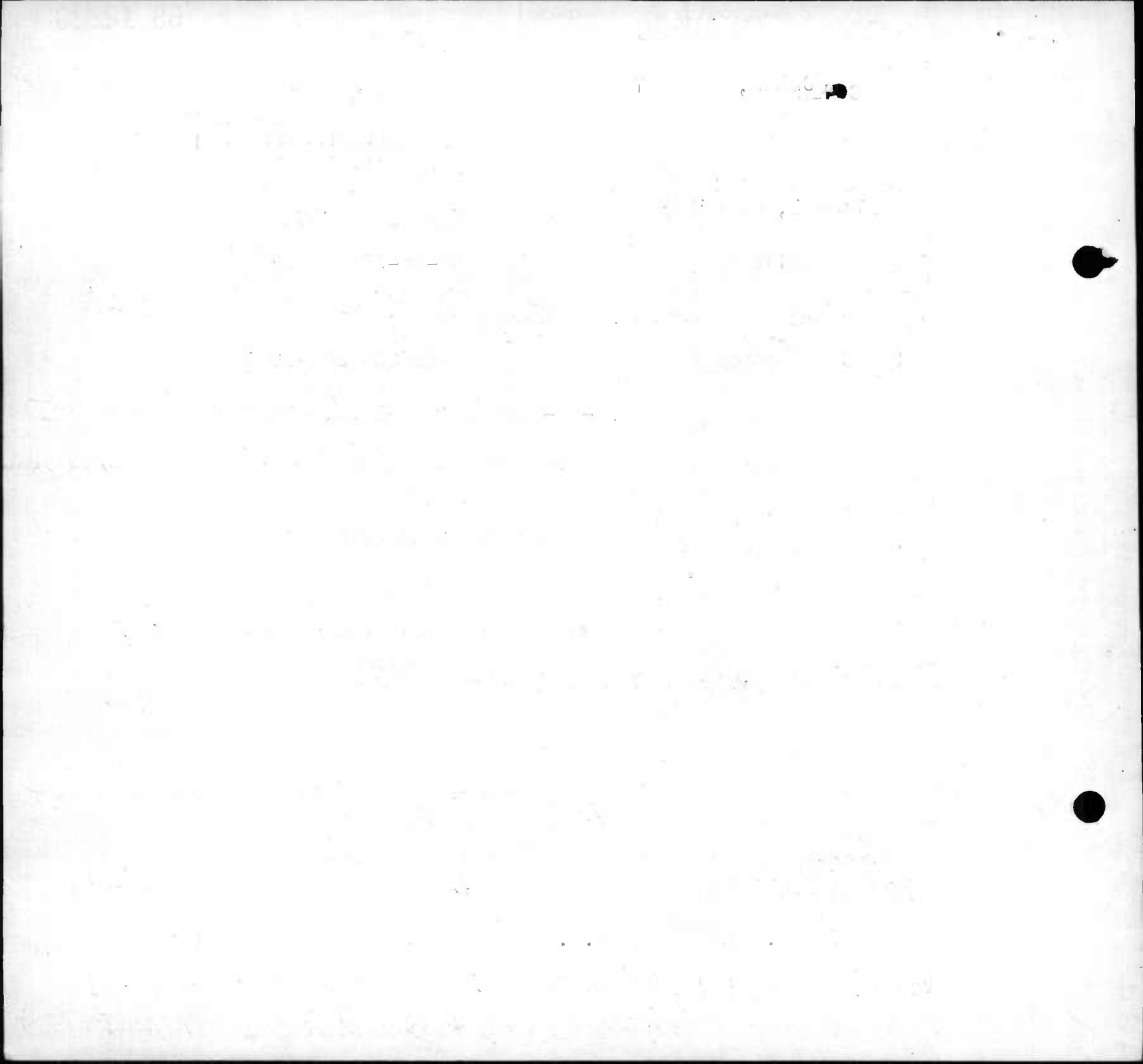
L-100		69 12225		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12225	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANNA LEVY				2. DATE AND HOUR OF DEATH 12-6-69 300 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL 42				A. STATE Maryland B. COUNTY			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 4002 Blongyle Ave. Apt E # 15 2720							
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-1-04	9. AGE (In years last birthday) 65	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Missouri
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY At Home		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ? Fine			14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Lawrence H. Levy ADDRESS 7902 Cromwell Circle #07		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 410.9 + I 250.9 (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Myocardial Infarction			Sudden	
			(B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis C.V.D.			5 years.	
			(C) Previous M.I. 5-24-69				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			Diabetes mellitus + Hypothyroidism			14 years.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Aug. 18, 1969 to Dec. 6, 1969 , that (I) (we) last saw the deceased alive on 11/25 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. A. Silver M.D.				23B. DATE SIGNED 12-6-69			
23C. PHYSICIAN'S NAME (Type) A. A. SILVER				23D. ADDRESS 6210 PARK HEIGHTS AVE. Baltimore, Md			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-69		24C. NAME OF CEMETERY or CREMATORY Hebrew Friendship		24D. LOCATION (City, town, or county) (State) E. Balto. St. Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Kelly		25C. FUNERAL DIRECTOR Sal Jeronimo		25D. ADDRESS 6010 Reisterstown Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

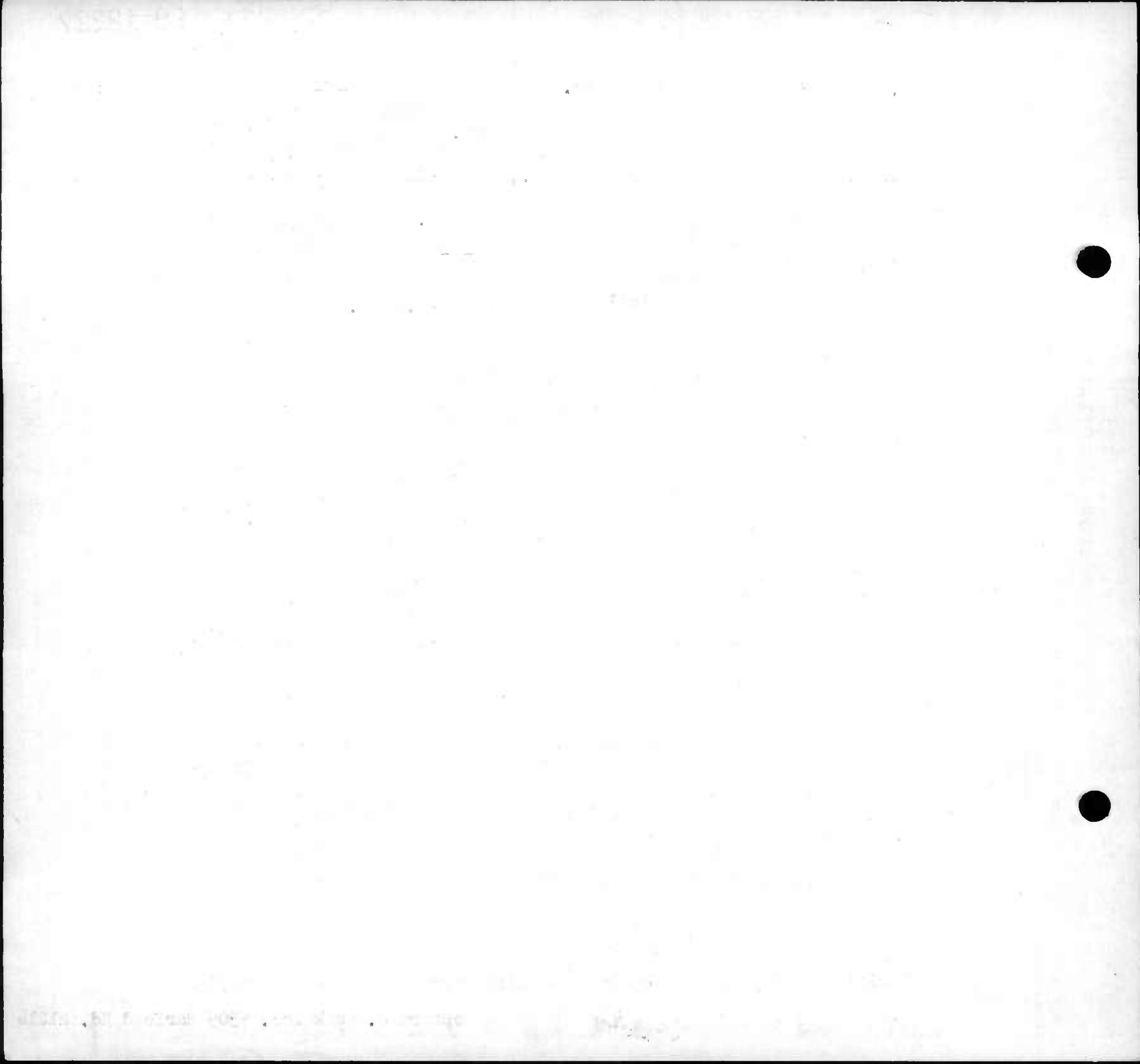
C-500		69 12226		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12226	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) COHEN, NAT				2. DATE AND HOUR OF DEATH 12/7/69 5:55 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER 8322 LOCH RAVEN BLVD							
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-01-07	9. AGE (In years lost birthday) 62	10. Under 1 Yr. <input type="checkbox"/> 11. Under 24 Hrs. <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive				10B. KIND OF BUSINESS OR INDUSTRY Womens Clothing		11. BIRTHPLACE (State or foreign country) N. Y. C.	
13. FATHER'S NAME ISAAC Cohen				14. MOTHER'S MAIDEN NAME REBECCA EDENBURG			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 060-10-5862		17. INFORMANT Reverend Chapels - New York City	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 396.0 I AORTIC & MITRAL INSUFFICIENCY ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. 419.15 RHEUMATIC HEART DISEASE				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) RHEUMATIC HEART DISEASE (C) AORTIC & MITRAL VALVE REGURGITATION			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 12-4-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED AORTIC & MITRAL DISEASE		20A. AUTOPSY (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11-6-69 to 12-7-69 , that (I) (we) lost saw the deceased alive on 12-7-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE TOM R. DEMESTER						23B. DATE SIGNED 12/7/69	
23C. PHYSICIAN'S NAME (Type) TOM R. DEMESTER M.D.						23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 12/9/69		24C. NAME OF CEMETERY OR CREMATORY West Chester Hills		24D. LOCATION (City, town, or county) (State) Hastings on Hudson N. Y.	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ed Spinnaker		25D. ADDRESS 6010 Reisterstown Rd	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

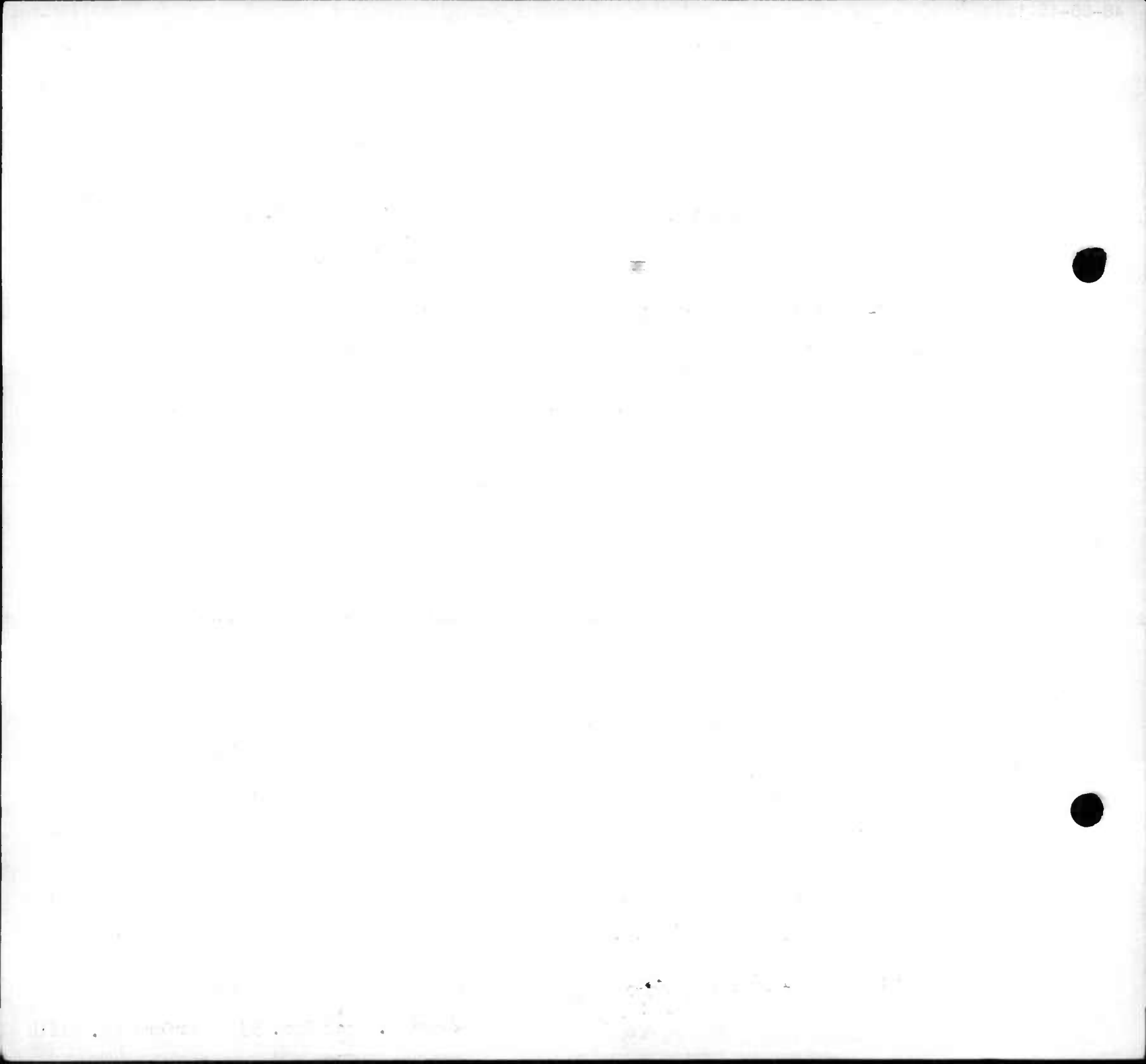
7-526 69 12227		BALTIMORE CITY HEALTH DEPARTMENT		69 12227	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Mr. John William Tankersley Jr.			2. DATE AND HOUR OF DEATH 12-8-69 7:05 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Keswick Home for Incurables of Balto., City 91			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY 1307		
5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 3-1-1900 9. AGE (In years last birthday) 69		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper Salesman			11. BIRTHPLACE (State or foreign country) Balto., Md.		
10B. KIND OF BUSINESS OR INDUSTRY Retail			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John William Tankersley			14. MOTHER'S MAIDEN NAME Ida Collins		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 217-14-1294		
17. INFORMANT Medical Records- Keswick			ADDRESS		
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF: (B) Gen. arteriosclerotic CVD DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5 June 1968 to 8 Dec 1969 , that (I) (we) last saw the deceased alive on 8 Dec 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Harold P. Bress MD				23B. DATE SIGNED 8 Dec 69	
23C. PHYSICIAN'S NAME (Type) Harold P. Bress MD				23D. ADDRESS Leonard J. Rack Inc. 5305 Harford Rd. 21214	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/69		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969			
25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Leonard J. Rack Inc. 5305 Harford Rd. 21214			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

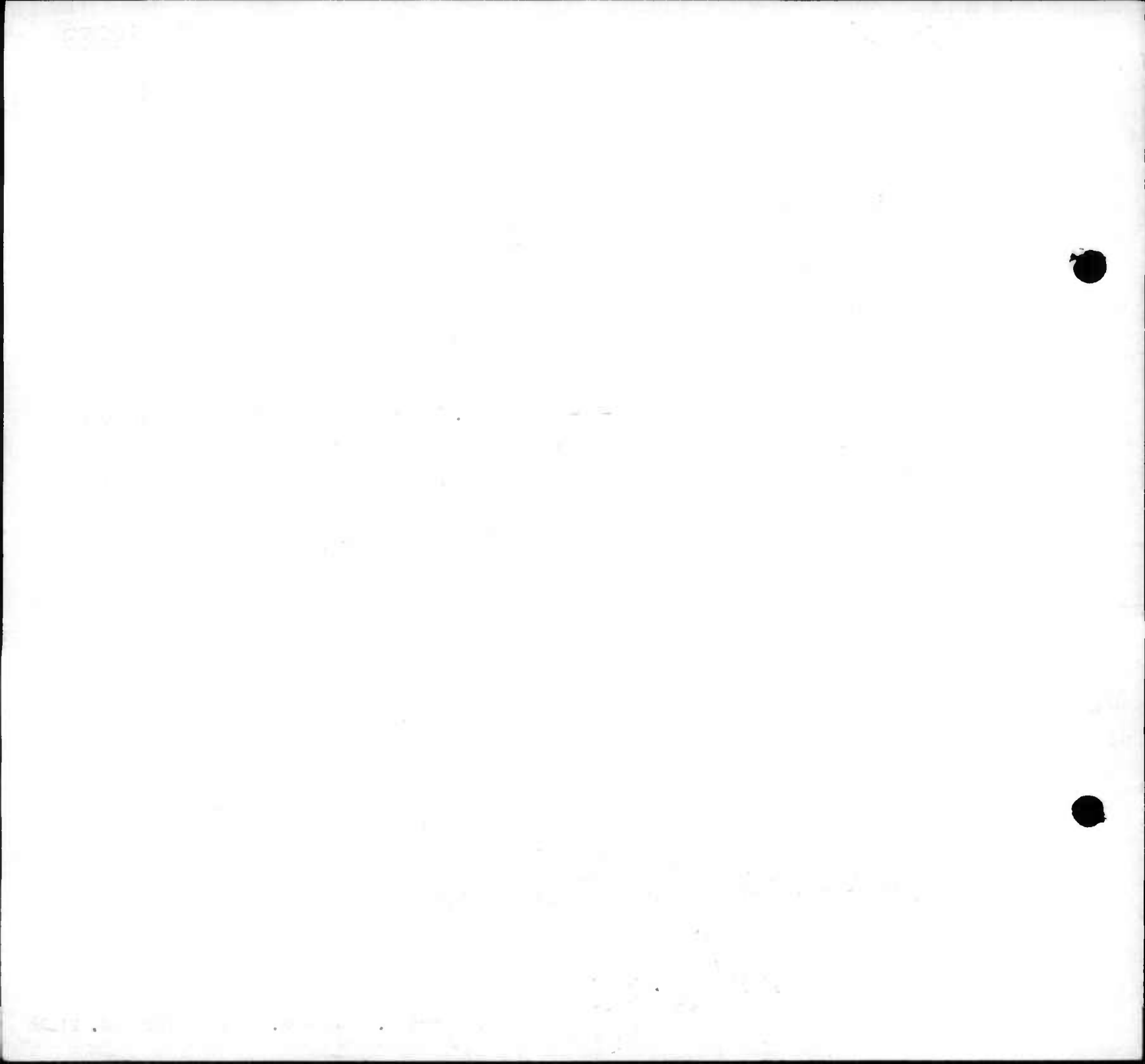
C-500		69 12228		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12228	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) JOHN Comi				2. DATE AND HOUR OF DEATH DECEMBER 8, 1969 11:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Baltimore City Hospital 4940 Eastern Avenue Baltimore, Md. 21224				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2611			
5. SEX Male				6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1895 10-3-1894				9. AGE (in years last birthday) 74		10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed				10B. KIND OF BUSINESS OR INDUSTRY Supper Club		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? United States				13. FATHER'S NAME Louis Comi			
14. MOTHER'S MAIDEN NAME Concetta Grande				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 215-22-8795				17. INFORMANT 4940 Eastern Avenue BCH Records: Baltimore, Md. 21224			
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CEREBROVASCULAR ACCIDENT DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINUTES YEARS			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from SEPTEMBER 23, 1969 to DECEMBER 8, 1969 that (1) (we) last saw the deceased alive on DECEMBER 8, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Michael M. McConnell, M.D.				23B. DATE SIGNED DECEMBER 8, 1969		23C. PHYSICIAN'S NAME (Type) Michael M. McConnell, M.D.	
23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. 21224				24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12/12/69				24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969				25B. NAME OF REGISTRAR Robert E. Fidelity, Md.		25C. FUNERAL DIRECTOR'S ADDRESS Leonard J. Rueck Inc. 5305 Harford Rd. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12229	
A-235 69 12229		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ELAINE E AUSTIN	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH 12-7-69 9 45 AM	
FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hosp		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W		E. STREET AND NUMBER 6002 Chesworth Road	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 07-03-09 9. AGE (In years last birthday) 60	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales lady		10B. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John W. Austin		14. MOTHER'S MAIDEN NAME Lillie Webster	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 214-14-9289	
17. INFORMANT Mr. Leroy Webster Deal Island Maryland		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Multiple pulmonary embolism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 m.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ca of ovary		(B) DUE TO, OR AS A CONSEQUENCE OF: 6 m.	
(C) 6 y.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) 0		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 1964 to Dec 7 1964 and that (I) (we) last saw the deceased alive on Dec 6 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Albert C.W. Montague		23B. DATE SIGNED 12-7	
23C. PHYSICIAN'S NAME (Type) ALBERT C.W. MONTAGUE		23D. ADDRESS Leonard J. Rueck Inc. 5305 Harford Rd. 21214	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69	
24C. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		24D. LOCATION (City, town, or county) (State) Deal Island Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Talley, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Rueck Inc.		ADDRESS 5305 Harford Rd. 21214	



1

D-622

69 12230

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12230

BIRTH NO.		1. NAME OF DECEASED (Type or Print) FELIX L. DRZEWIECKI		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour December 6, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 3303 Kentucky Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour December 6, 1969 9:30 P. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2633	
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 11/10/1900		10. AGE (In years last birthday) 69	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		15. MOTHER'S MAIDEN NAME Unknown	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 215-22-1497		18. INFORMANT ADDRESS Mr. William A. Parris 153 Greenmeadow Drive	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 7, 1969					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69		24C. NAME of CEMETERY or CREMATORY St. Peter's Church	
24D. LOCATION (City, town, or county) (State) Baltimore Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969			
25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck Inc. 5305 Harford Rd. 21214			

DESS: 00

10/10/1900

10/10/1900

X

X

X

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200		69 12231		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12231	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MECK, CHARLES H.				2. DATE AND HOUR OF DEATH December 10th 1969 6:40 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) THE UNION MEMORIAL HOSPITAL 44				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1704 NORTH BOURNE RD BALTIMORE MD 21218			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-6-88	9. AGE (In years last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman			10B. KIND OF BUSINESS OR INDUSTRY Merk Co		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME Adolph Meck				14. MOTHER'S MAIDEN NAME Eugenie Wahl			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-7813		17. INFORMANT Mrs Lula M Meck		ADDRESS Same	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If in Baltimore City, give exact location) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? 21D. TIME OF INJURY (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from November 30 1969 to December 10th 1969 that (I) (we) last saw the deceased alive on December 10th 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Tzen-Chi Fan-Chiang 23B. DATE SIGNED 23C. PHYSICIAN'S NAME (Type) TZEN-CHI FAN-CHIANG 23D. ADDRESS Union Memorial Hospital 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12/13/69 24C. NAME OF CEMETERY OR CREMATORY Loudon Park 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969 25B. NAME OF REGISTRAR Robert E. Taylor 25C. FUNERAL DIRECTOR Leonard J. Buck Inc. ADDRESS Baltimore, Maryland							

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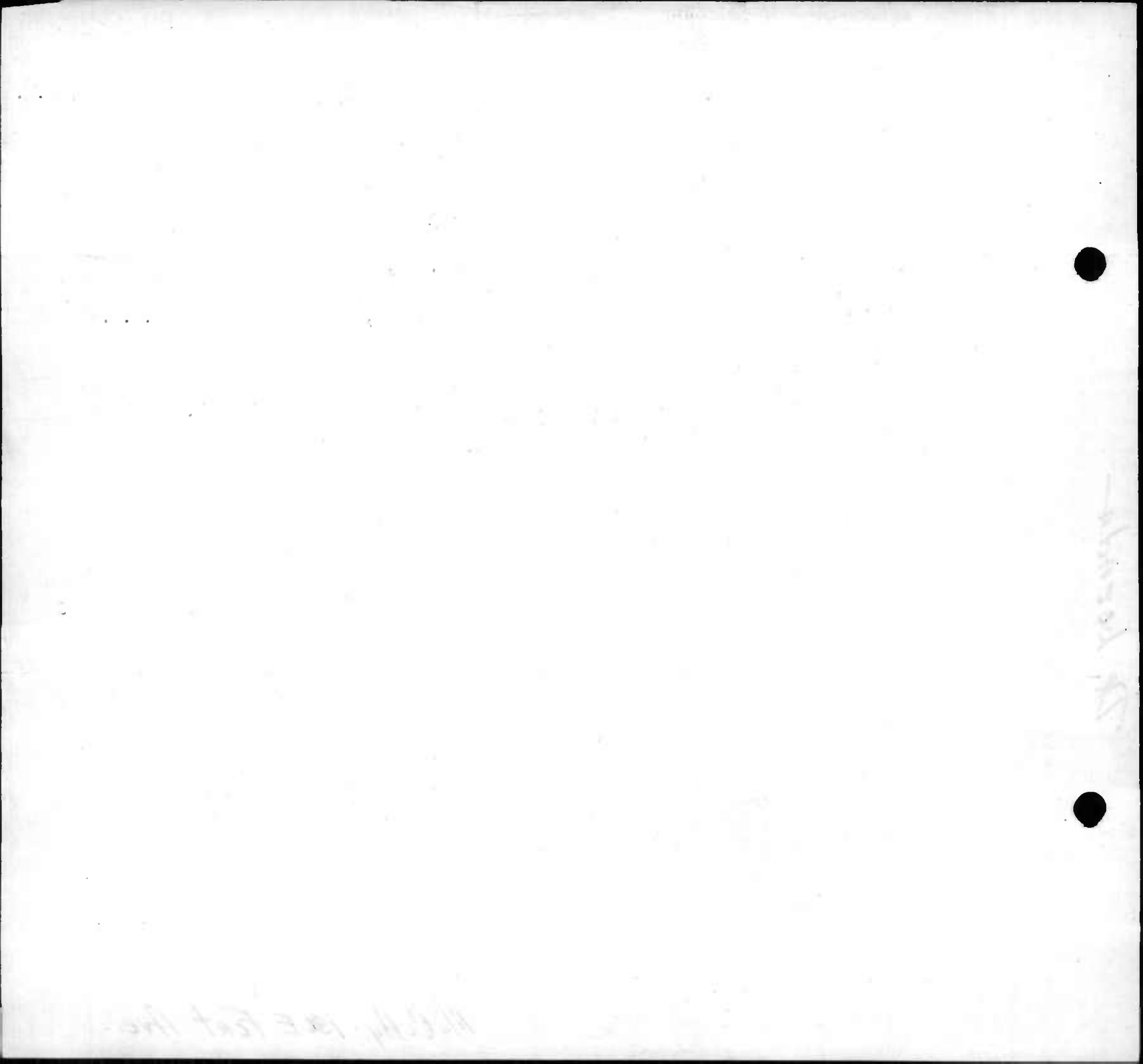
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

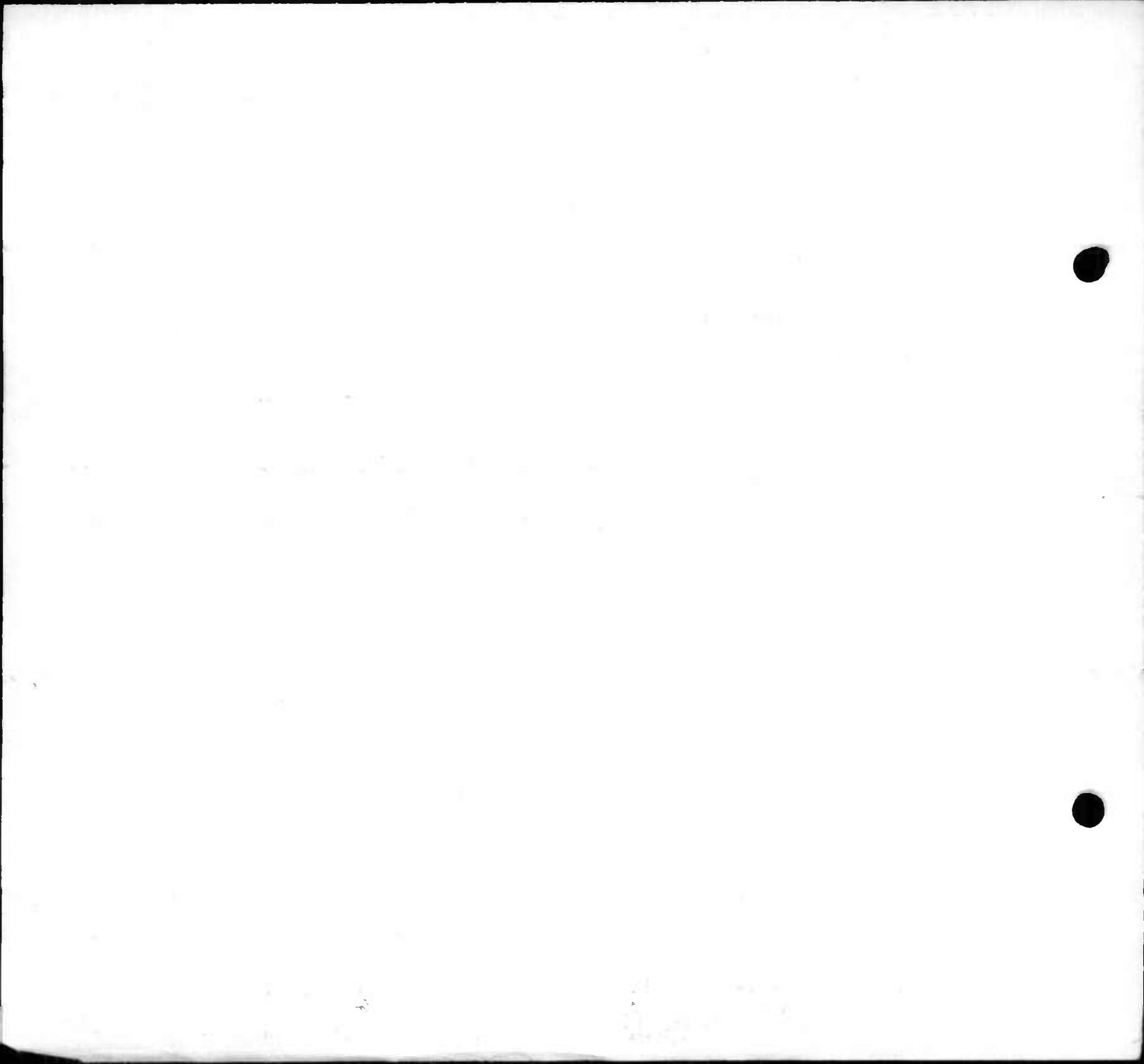
M-600		69 12232		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12232	
BIRTH NO.				1					
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
WILLIAM W. MOYER				12/6/69 7 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE		B. COUNTY			
1135 WILLIAM STREET				MARYLAND		BALTIMORE		2403	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER					
				1135 WILLIAM STREET					
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		OCT. 14, 1919		50	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
BAKER				BAKERY		BALTIMORE, MARYLAND		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
WILLIAM MOYER				NANCY STEIN 414 FOLSON ST.					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				217 05 3902					
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Terminal Pneumonia					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES				Generalized carcinoma					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:					
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 10/17/69 to 12/5/69 19 that (I) (we) last saw the deceased alive on 12/5/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
Richard Lozada				12/8/69					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
RICHARD LOZADA				1225 S. Lee St. Bk. Mt. 2123					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		12/10/69		HOLY CROSS CEMETERY		BALTIMORE, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
DEC 11 1969		Richard E. Lozada		McCarty		130 E. Fort Ave.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

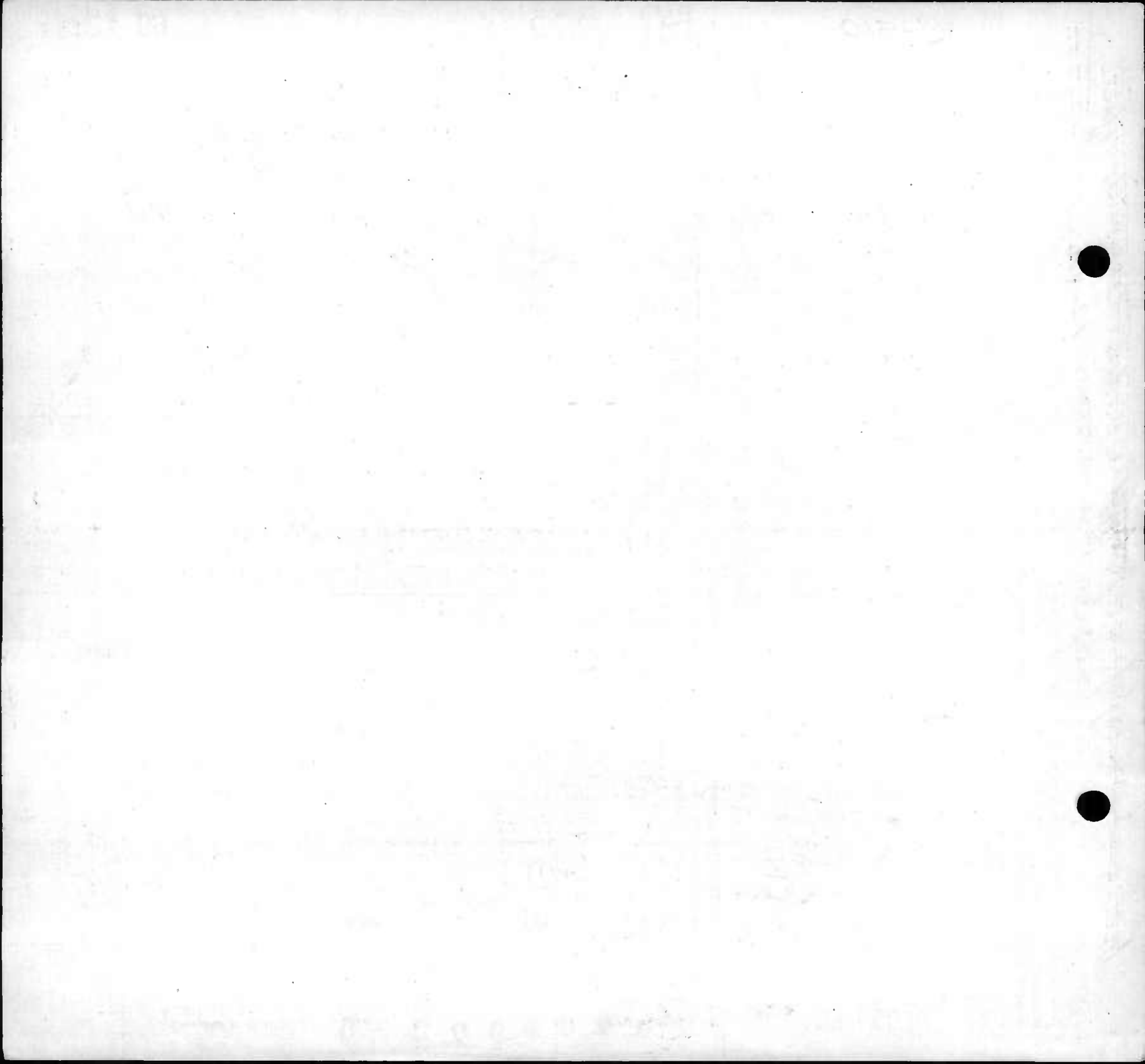
D-535		69 12233		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12233	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Denton Dorothy Bowen</u>				2. DATE AND HOUR OF DEATH <u>12-7-69</u> <u>1:30 A</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland General Hospital</u>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>md.</u> B. COUNTY <u>1202</u>			
5. SEX <u>Female</u> 6. RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>8-19-03</u>		9. AGE (in years last birthday) <u>66</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Medical Records Librarian</u>						11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Bowen</u>						14. MOTHER'S MAIDEN NAME <u>B. Hambleton</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>						16. SOCIAL SECURITY NO. <u>212-32-1203</u>		17. INFORMANT <u>Lloyd Denton - 3404 St. Paul Street</u> <u>admission record husband - same as dec.</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH <u>LARYNGEAL CANCER - BRONCHITIS</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ISCHEMIC HEART DISEASE</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>DAYS</u> <u>715</u>	
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>12/1</u> 19 <u>69</u> to <u>12/7</u> 19 <u>69</u> and that (I) (we) last saw the deceased alive on <u>12/7</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Enrique A. MD</u>						23B. DATE SIGNED <u>12/7/69</u>			
23C. PHYSICIAN'S NAME (Type) <u>ENRIQUE A. MD</u>						23D. ADDRESS <u>MARYLAND GEN. HOSP.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-10-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 11 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Armacost</u>		ADDRESS <u>Funeral Chapel-4600 Liberty Hts</u>			



FUNERAL DIRECTOR: IMPORTANT

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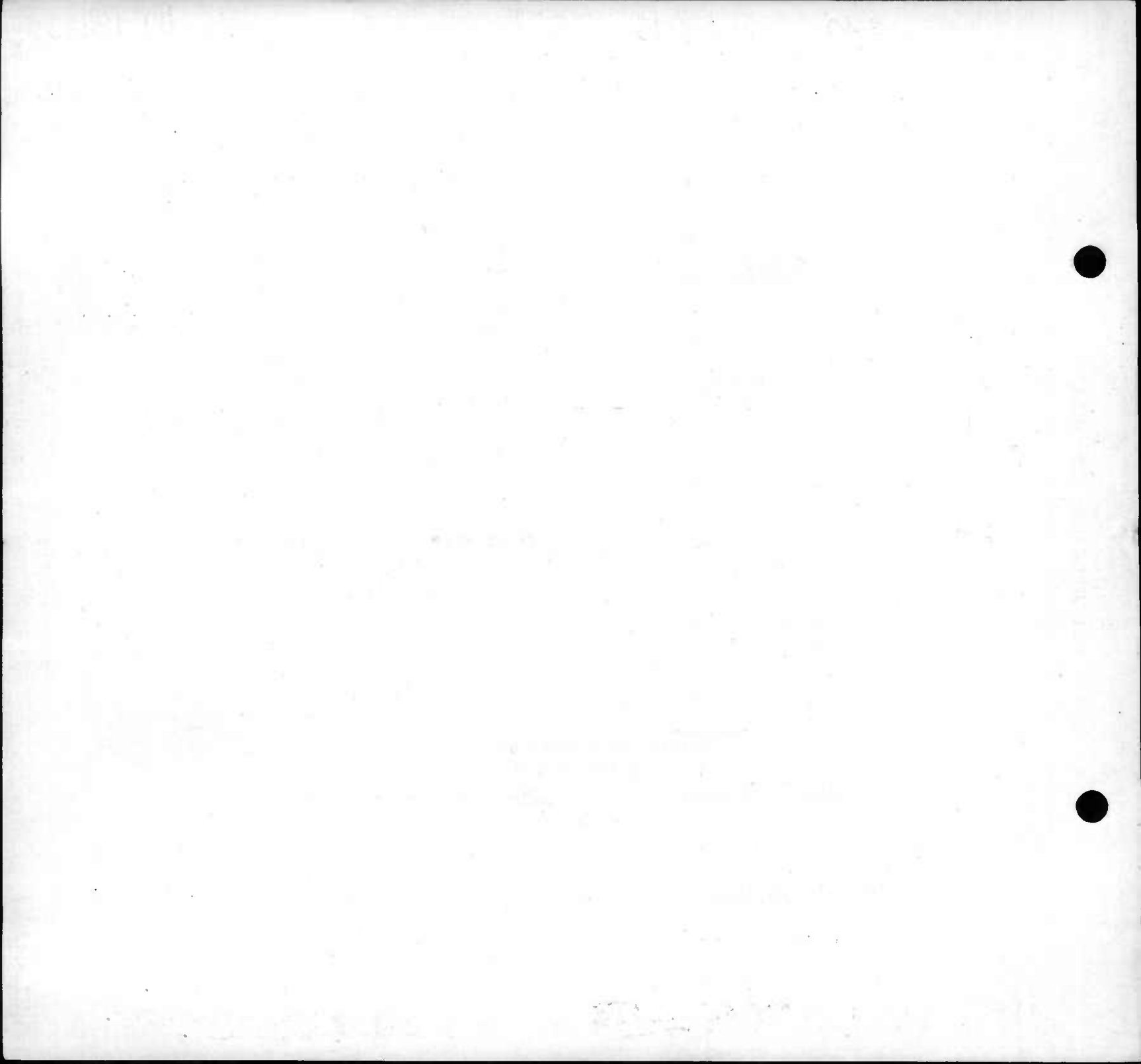
C-510		69 12234		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		69 12234	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CANBY BLANCHE MARIE		2. DATE AND HOUR OF DEATH 12/7/69		2 15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MONTEBELLO HOSPITAL 91 BALTIMORE, MD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE, MD E. STREET AND NUMBER 8119 Hillendale Rd 21234					
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/26/75	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10B. KIND OF BUSINESS OR INDUSTRY FAMILY WELFARE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME WINFIELD S CANBY				14. MOTHER'S MAIDEN NAME ANNE AFFERBOUX					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 219-30-9414		17. INFORMANT Margaret Mattes, neice, 5603 Sinclair Lane					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Acute Pulmonary Embolism 1 hr Cerebral Thrombosis with Hemiplegia 14 mon Atherosclerotic Cardiovascular Disease YEARS					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (this hospital) attended the deceased from 19 to 12/7/69 19 that (we) last saw the deceased alive on 12/7/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE J. Fuxa. MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/7/69			
23C. PHYSICIAN'S NAME (Type) JORGE G. FUXA MD.				23D. ADDRESS 2201 Argonne Dr.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/69		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane					



FUNERAL DIRECTOR: IMPORTANT

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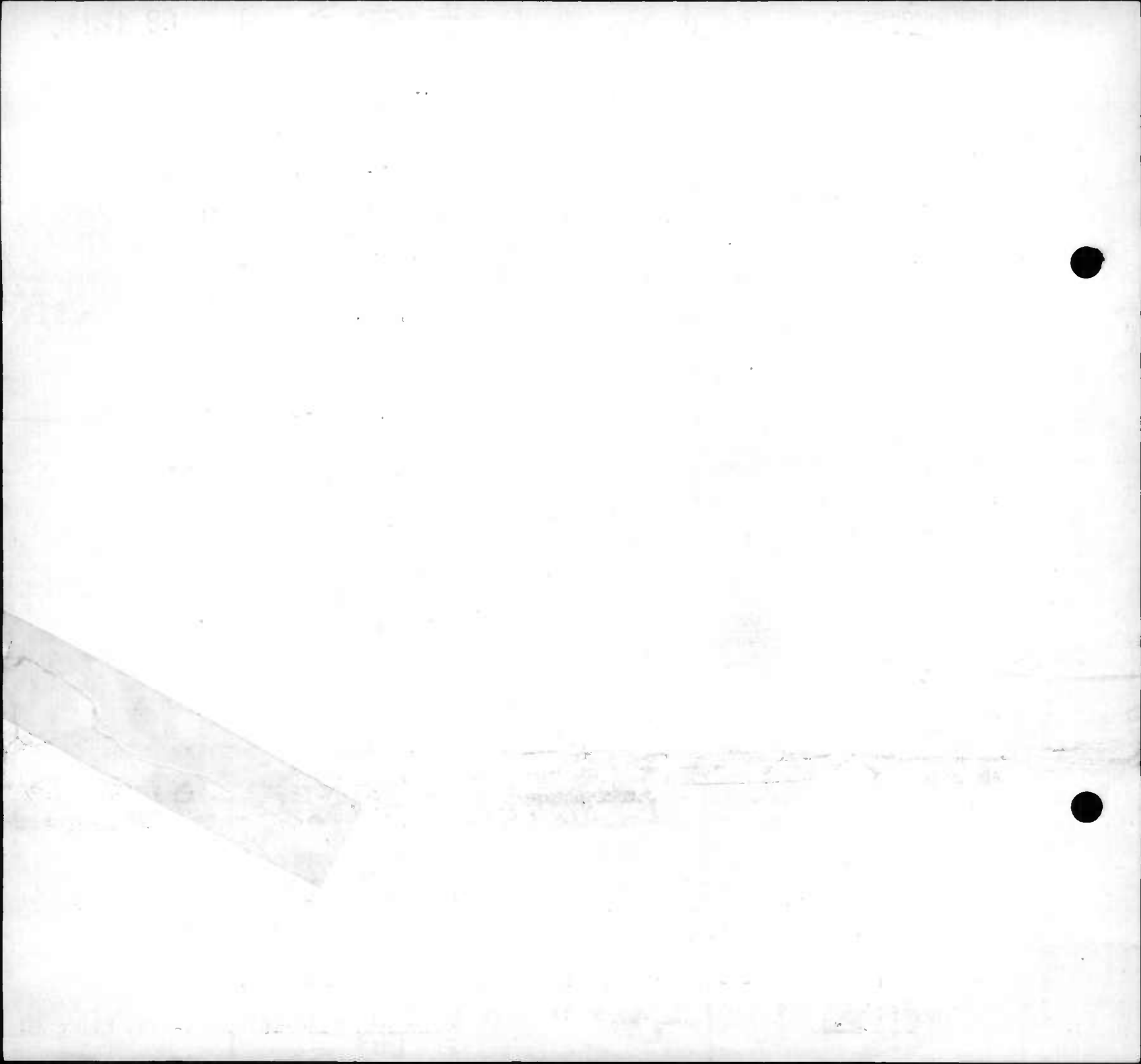
B-240		69 12235		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12235	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				DANIEL EDGAR BUCKLEY			
2. DATE AND HOUR OF DEATH				12/6/69 6 ¹² P.M. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
JOHNS HOPKINS HOSPITAL				A. STATE B. COUNTY			
FULL NAME OF (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				449 905 N. BRADFORD ST. 703			
BALTIMORE, M.D.				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
33				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER				MARYLAND			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
M		CAUC.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6/2/20 49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday)	
Mechanic				General Motors		49	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Edgar Buckley				ROSE SHELDON		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes WW 2 Army				214-10-0343		Mary Freese Buckley, wife, above	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4/10.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) ASCVD DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A):							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2						YES	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from ON 12/6 19 69 to 12/6 19 69 and that (I) (we) lost saw the deceased alive on 12/6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Ralph DeFrongo, M.D.						12/6/69	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
RALPH DEFONZO						JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/11/69		Baltimore National Cem		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 11 1969		Robert E. Taylor, M.D.		Schamunek Funeral Home, Inc.		2601 E. Madison St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

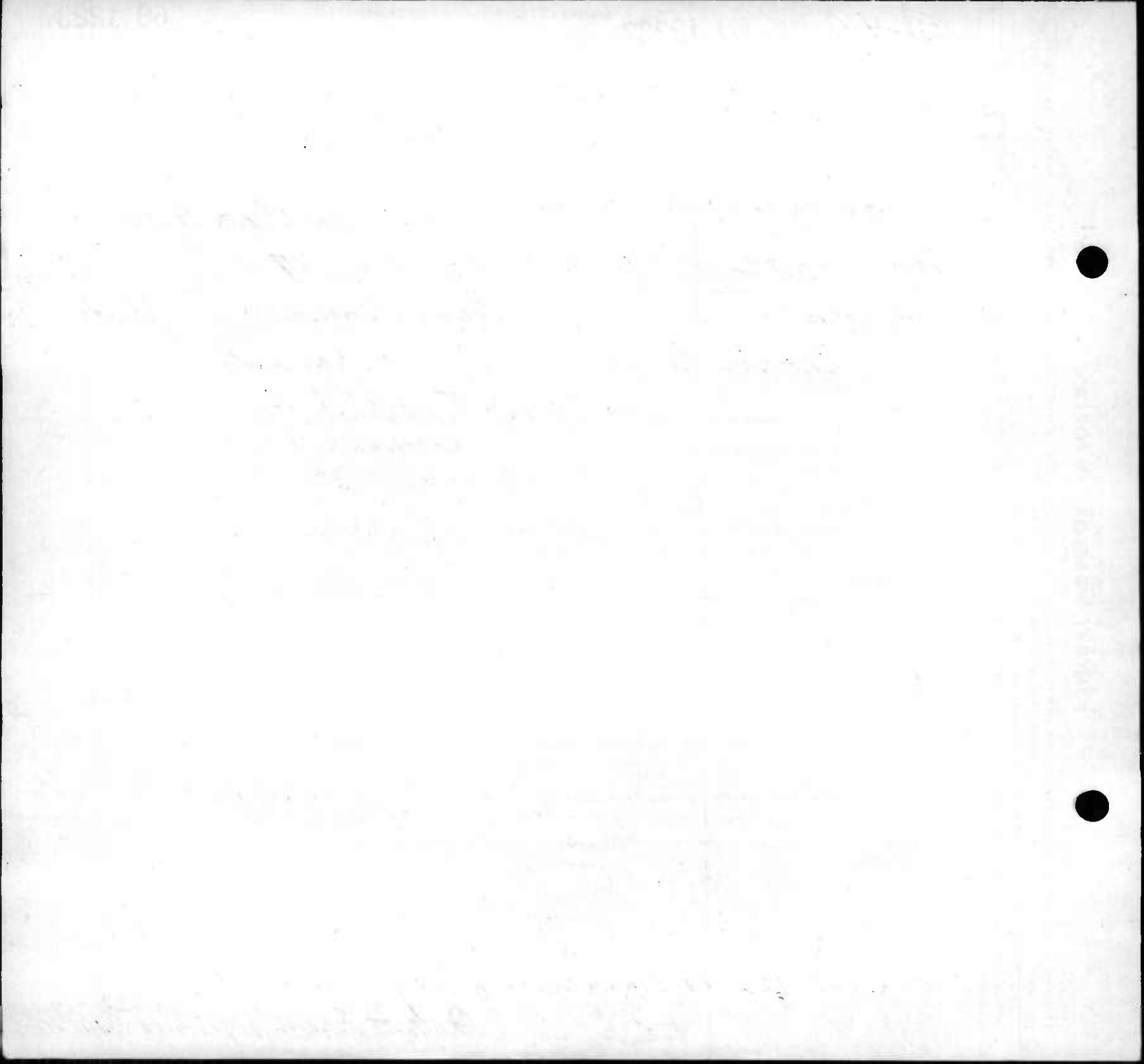
A-500		69 12236		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12236	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) AMEY THELMA M.			
2. DATE AND HOUR OF DEATH 12-5-69 430 P.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 Suici Hospital of Balto Inc.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2798			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3718 GARRISON							
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7-14-05	9. AGE (In years last birthday) 64	If Under 1 Yr. Months Days		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Balto, Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME George E. Amey				14. MOTHER'S MAIDEN NAME Keyser			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NO		17. INFORMANT ADDRESS George E. Amey-601 Myers Drive 21228			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Dissecting abdominal aortic aneurysm -				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours -			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Abdominal Aneurysm -				Years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Diabetic Urethritis				Years -			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 5 (5) 1969 to Dec 15 (5) 1969 , that (I) (we) last saw the deceased alive on Dec 15 (5) 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. J. Drzewanski M.D.				23B. DATE SIGNED 12-5-69		23C. PHYSICIAN'S NAME (Type) W. J. DRZEWSKI M.D.	
23D. ADDRESS Suici Hospital				23E. FUNERAL DIRECTOR		ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-9-69		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969				25B. NAME OF REGISTRAR Armacost Funeral Chapel-4600 Liberty Hts			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

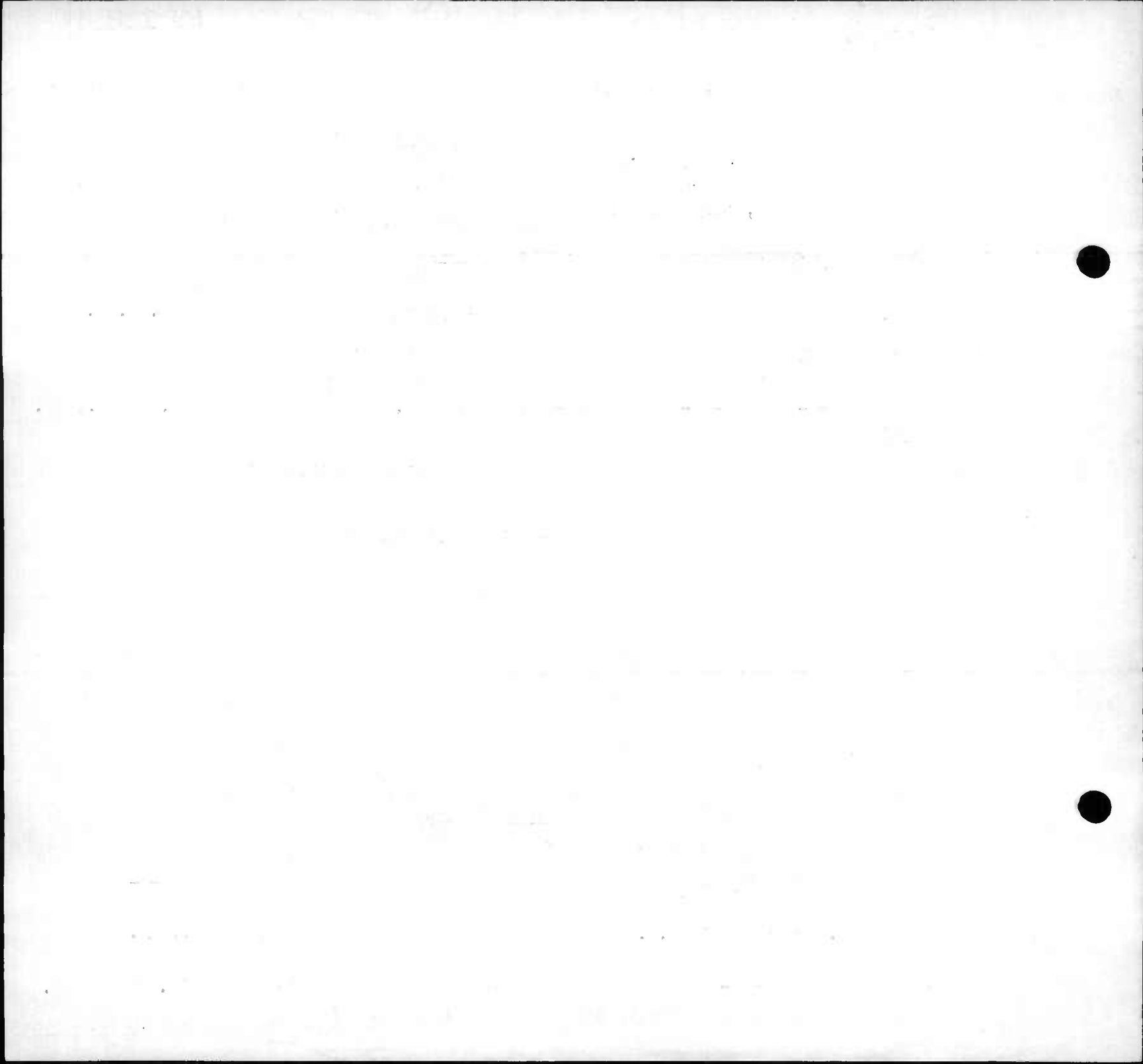
W-410		69 12237		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12237	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Curtis A. Wolf</u>				2. DATE AND HOUR OF DEATH <u>12-9-69</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90 HAVEN NURSING HOME</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>3810 Gwynn Oak Ave</u>							
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-1-1892</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Wolf</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>213-01-9786</u>		17. INFORMANT <u>John C. Shetter</u>		ADDRESS <u>5117</u>	
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Greenwich Ave #22</u> <u>Regenerative State</u> <u>Marked Cerebrovascular</u> <u>Diabetes - Heart Regeneration</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-9-68</u> to <u>12-9-69</u> , that (I) (we) last saw the deceased alive on <u>12-7-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Thomas G. Abbott</u>				23B. DATE SIGNED <u>12-9-69</u>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS					
<u>Thomas G. Abbott</u>		<u>4509 Liberty Hwy</u>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>12-12-69</u>		<u>Libertine Cemetery</u>		<u>BALTO. MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 11 1969</u>		25B. NAME OF REGISTRAR <u>John E. Kelly</u>		25C. FUNERAL DIRECTOR <u>Antacost Funeral Chapel</u>		ADDRESS <u>4600 Hight Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>K-524 69 12238 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH REG. NO. 69 12238</p>			
<p>BIRTH NO. 1. NAME OF DECEASED (Type or Print) KUNKEL, ALLAN HENRY</p>		<p>2. DATE AND HOUR OF DEATH DECEMBER 8, 1969 12:40 A M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 4010 Putty Hill Road 21236</p>	
<p>5. SEX Male</p>	<p>6. RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 5-5-94</p>
<p>9. AGE (In years last birthday) 75</p>		<p>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.</p>	<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter</p>
<p>10B. KIND OF BUSINESS OR INDUSTRY Retired</p>		<p>11. BIRTHPLACE (State or foreign country) Maryland</p>	<p>12. CITIZEN OF WHAT COUNTRY? U. S. A.</p>
<p>13. FATHER'S NAME August Kunkel</p>		<p>14. MOTHER'S MAIDEN NAME Katherine Ritzel</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 4-1-18 to 2-19-19</p>	<p>16. SOCIAL SECURITY NO. 214-14-48-30</p>	<p>17. INFORMANT Records ADDRESS VA, Hosp. 3900 Loch Raven Blvd. Balto., Md.</p>	
<p>18. CAUSE OF DEATH</p> <p>412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CONGESTIVE CARDIAC FAILURE II ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Ischemic Heart Disease</p>			<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION 0</p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) No</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (X) (this hospital) attended the deceased from November 11, 19 69 to December 8, 19 69, that (X) (we) last saw the deceased alive on December 8, 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.</p>			
<p>23A. SIGNATURE M. J. Shafi</p>		<p>Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/></p>	<p>23B. DATE SIGNED 12-8-69</p>
<p>23C. PHYSICIAN'S NAME (Type) M. Javad Shafi M.D.</p>		<p>23D. ADDRESS 3900 Loch Raven Blvd, Balto., Md. 21218</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 12-10-69</p>	<p>24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery</p>	<p>24D. LOCATION (City, town, or county) (State) Parkville Balto. Md.</p>
<p>25A. DATE RECEIVED BY HEALTH DEPT. DEC 11 1969</p>		<p>25B. NAME OF RECORDED</p>	<p>25C. FUNERAL DIRECTOR'S ADDRESS Dassahn Funeral Home 7401 Belair Road 21236</p>



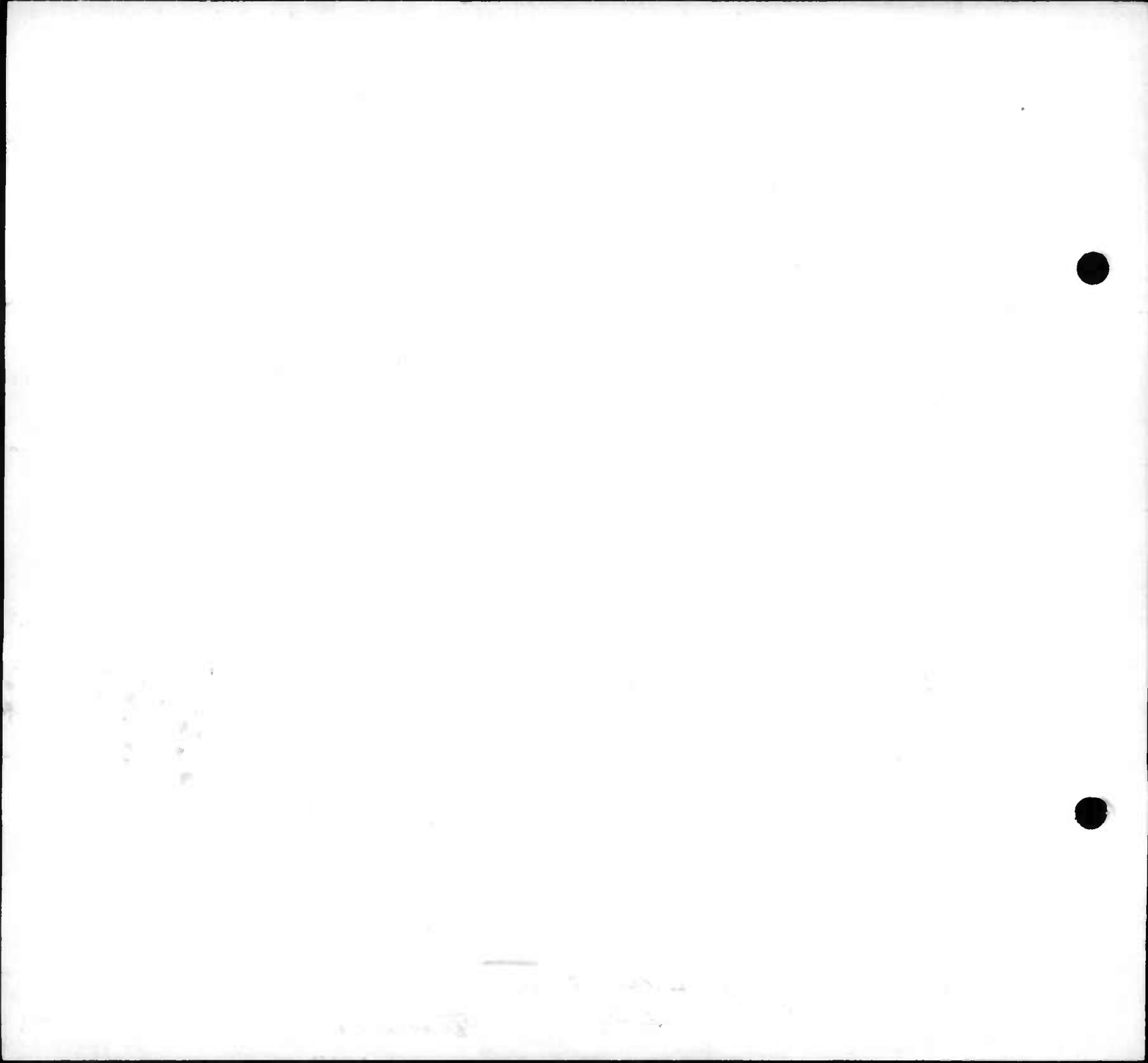
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-613		69 12239		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12239	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) WILLIAM R. TRIBETT				2. DATE AND HOUR OF DEATH 12-8-69 11:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 2102			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South Balt Gen Hosp				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 1305 W. Ostden Street			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-23-1900	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Expeditor		10B. KIND OF BUSINESS OR INDUSTRY Martin - Co.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? US.	
13. FATHER'S NAME OLIVE Tribett				14. MOTHER'S MAIDEN NAME JENNIE LANK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-05-0308		17. INFORMANT Nadine B. Tribett - Same		ADDRESS	
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ga Arteriosclerotic Cardiovascular disease				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that at (this hospital) attended the deceased from 11:00 a.m. 12-8-19 69 9:15 pm 12-7-19 69 to 11:00 am 12-8-19 69 , that it (we) last saw the deceased alive on 11:00 am 12-8-19 69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) did not view the body after death.							
23A. SIGNATURE [Signature]				23B. DATE SIGNED 12-8-69			
23C. PHYSICIAN'S NAME (Type) HENRY CITEN MD				23D. ADDRESS 3001 S. Hanover St			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-20-69		24C. NAME OF CEMETERY or CREMATORY Lakeview Memorial Park		24D. LOCATION (City, town, or county) (State) Carroll Co. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR John C. Miller Inc		ADDRESS 6415 Belair Rd. - 21206	

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>I-340 69 12240 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12240</p>	
<p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) <u>Robert B. Fairley</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><u>7 MERCY HOSPITAL</u></p>		<p>2. DATE AND HOUR OF DEATH</p> <p><u>Dec 8, 1969</u> <u>1-15</u> a.m.</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <p>A. STATE <u>B. Maryland</u> B. COUNTY <u>1348</u></p>		<p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>E. STREET AND NUMBER</p> <p><u>1522 Baldwin St</u></p>			
<p>5. SEX</p> <p><u>Male</u></p>	<p>6. RACE</p> <p><u>White</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH</p> <p><u>9-12-12</u></p>
<p>9. AGE (In years last birthday) <u>57</u></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>RETIRED</u></p>	<p>11. BIRTHPLACE (State or foreign country)</p> <p><u>? Va.</u></p>
<p>12. CITIZEN OF WHAT COUNTRY?</p>		<p>13. FATHER'S NAME</p> <p><u>Fairley Archie K</u></p>	
<p>14. MOTHER'S MAIDEN NAME</p> <p><u>Laura Botte</u></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>WW2</u></p>	
<p>16. SOCIAL SECURITY NO.</p> <p><u>unknown</u></p>		<p>17. INFORMANT <u>Wife</u> ADDRESS</p>	
<p>18. CAUSE OF DEATH</p> <p><u>569.41</u></p>			
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>Respiratory failure</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p><u>Chronic febrile lung disease and</u></p> <p>(B) Congestive Heart Failure</p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p> <p><u>Post OP Small Bowel Resection</u></p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p> <p><u>12-3-67</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p><u>Jejunal Perforation</u></p>	
<p>20A. AUTOPSY? (Yes or No) <u>No</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/> <u>No</u></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>11-24</u> 19 <u>69</u> to <u>12-8</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12-7</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.</p>			
<p>23A. SIGNATURE</p> <p><u>Stanley Silber, M.D.</u></p>		<p>23B. DATE SIGNED</p> <p><u>12-8-69</u></p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p><u>Stanley Silber, M.D.</u></p>		<p>23D. ADDRESS</p> <p><u>MERCY HOSPITAL</u></p>	
<p>24A. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><u>Burial</u></p>		<p>24B. DATE</p> <p><u>12/11-69</u></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p><u>Balto National</u></p>		<p>24D. LOCATION (City, town, or county) (State)</p> <p><u>Baltimore Md</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p><u>DEC 11 1969</u></p>		<p>25B. NAME OF REGISTRAR</p> <p><u>Robert E. Fairley</u></p>	
<p>25C. FUNERAL DIRECTOR</p> <p><u>Frank H. Seitz</u></p>		<p>ADDRESS</p> <p><u>814 W 36 St, Baltimore</u></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

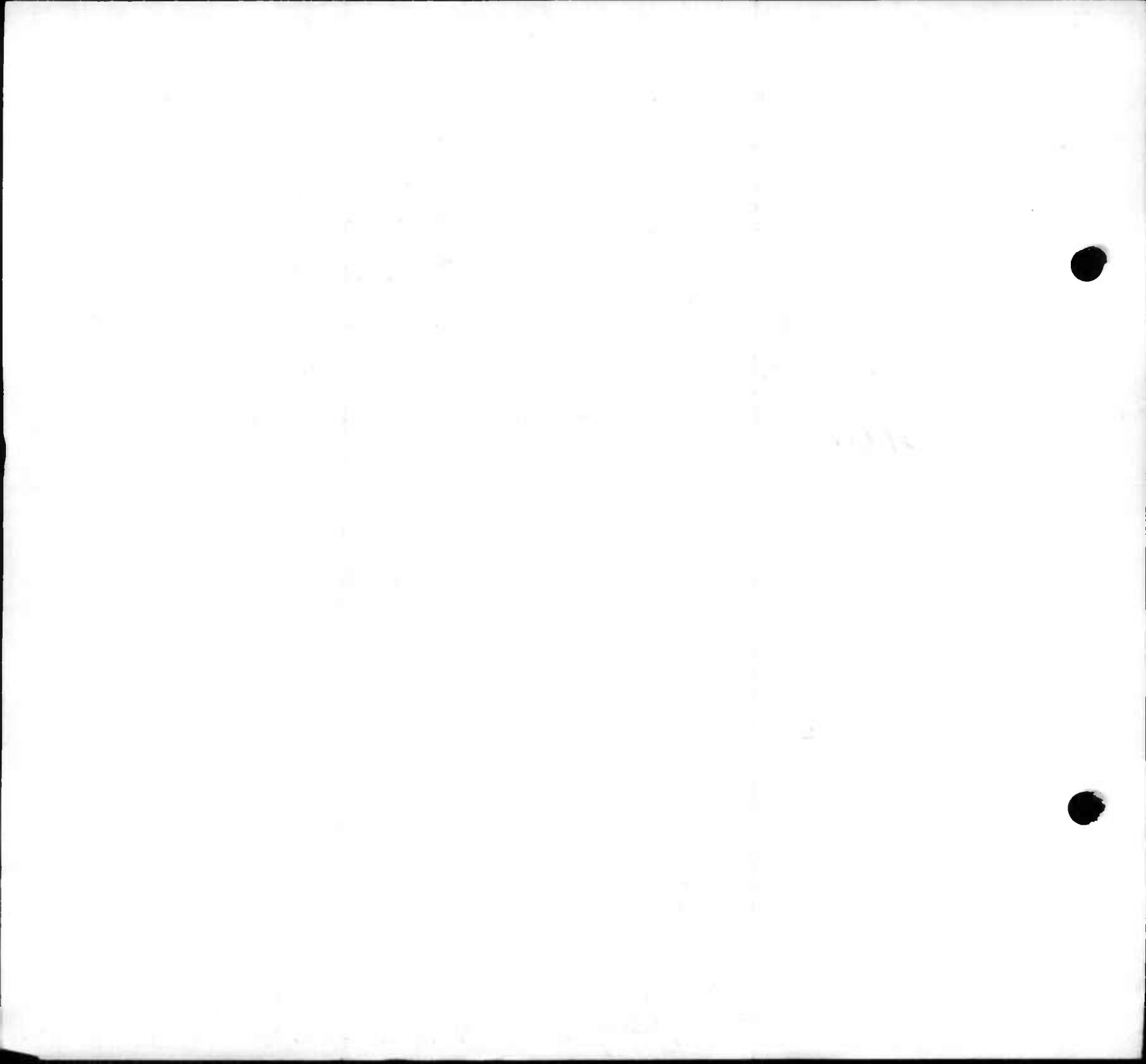
A-654		69 12241		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12241	
BIRTH NO.				2			
1. NAME OF DECEASED (Type or Print) ARNOLD, MARGARET				2. DATE AND HOUR OF DEATH 12-6-69 7:45 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Harbor View Nursing Home 1213 Light St				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Me B. COUNTY 2102 C. CITY OR TOWN Balto D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 604 Myrtle St			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1986	9. AGE (In years lost birthday) 84	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Char woman		10B. KIND OF BUSINESS OR INDUSTRY Me		11. BIRTHPLACE (State or foreign country) Me		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Charles Allen Griffith				14. MOTHER'S MAIDEN NAME Margaret Van Skiver			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-05-9119		17. INFORMANT Laving Van Sant		ADDRESS 5662 Gayland Rd.	
18. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pneumonia CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic Hypertension (B) DUE TO, OR AS A CONSEQUENCE OF: Cerebro-Vascular Disease (C) Cerebro-Vascular Accident APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days				ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from October 19 69 to December 6 19 69 , that (I) was lost saw the deceased alive on 12-6-69 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) did not view the body after death.							
23A. SIGNATURE Rolando V. Goco M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-7-69	
23C. PHYSICIAN'S NAME (Type) Dr. Rolando Goco				23D. ADDRESS 1213 Light St.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/10/69		24C. NAME OF CEMETERY or CREMATORY Louisa Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR Amber [illegible]		ADDRESS 1328 Sulphur Sp. Rd.	

604 W yth

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

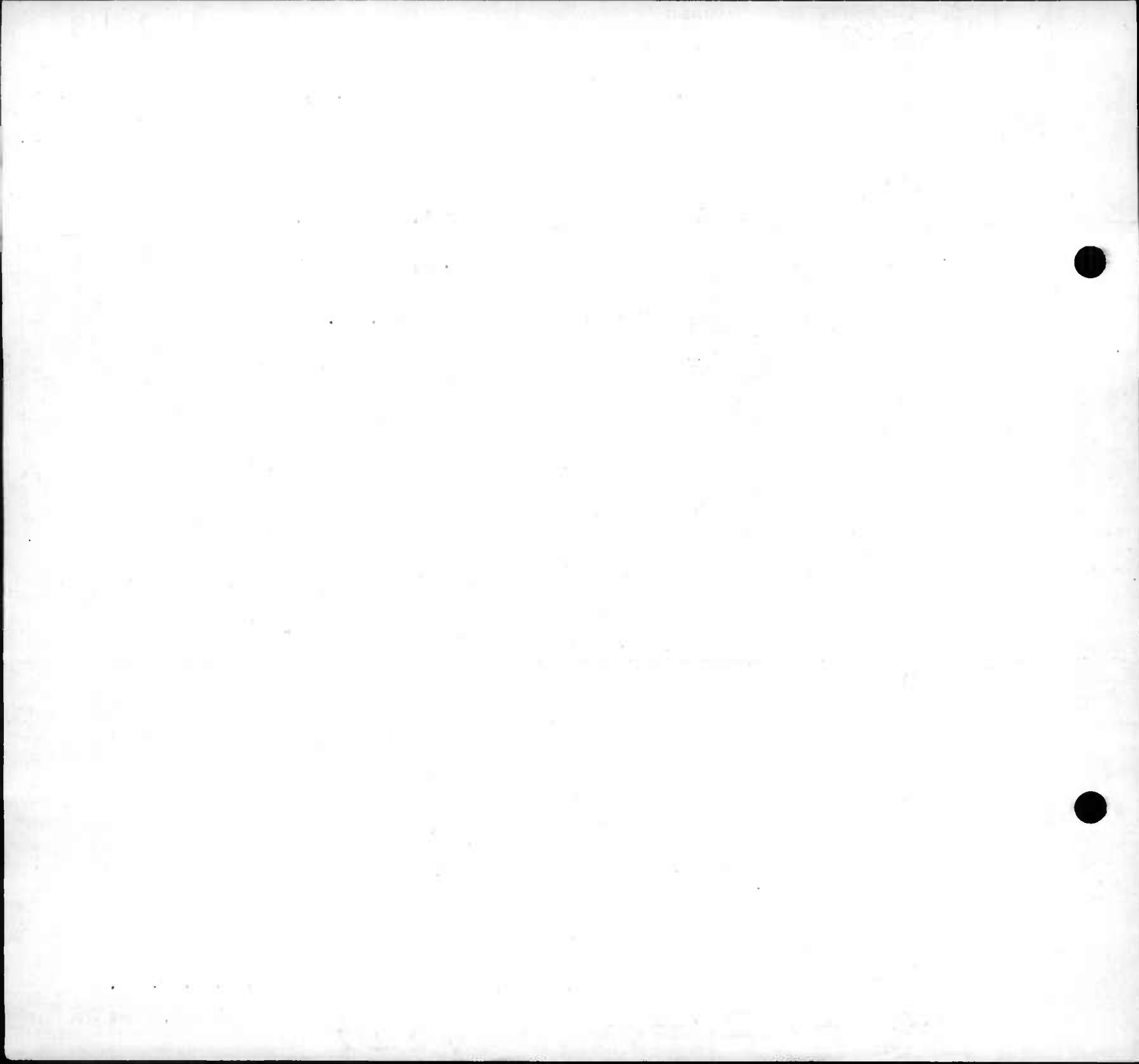
R-500		69 12242		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X		REG. NO. 69 12242	
1. NAME OF DECEASED (Type or Print) Ryan, Francis W.				2. DATE AND HOUR OF DEATH 12-6-69 8:40 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 40 Saint Agnes Hospital Caton & Wilkens Avenues. Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Howard C. CITY OR TOWN Baltimore E. STREET AND NUMBER 1957 Railroad Avenue D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 8, 1913		9. AGE (In years last birthday) 56	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed				10B. KIND OF BUSINESS OR INDUSTRY Tavern		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Francis E Ryan				14. MOTHER'S MAIDEN NAME Nellie Schieve		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII			
16. SOCIAL SECURITY NO. 213-09-9313				17. INFORMANT Mary Chesgreen 1957 Railroad Ave					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 12/10/69 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) 21E. INJURY OCCURRED 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 19 to 19 that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE M. Horn 23B. DATE SIGNED 12-7-69 23C. PHYSICIAN'S NAME (Type) M. Horn 23D. ADDRESS 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12/10/69 24C. NAME OF CEMETERY or CREMATORY Baltimore National Cem. 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969 25B. NAME OF REGISTRAR Robert E. Taylor 25C. FUNERAL DIRECTOR Ambrose Inc. 1328 Sulphur Sp. Rd.									



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

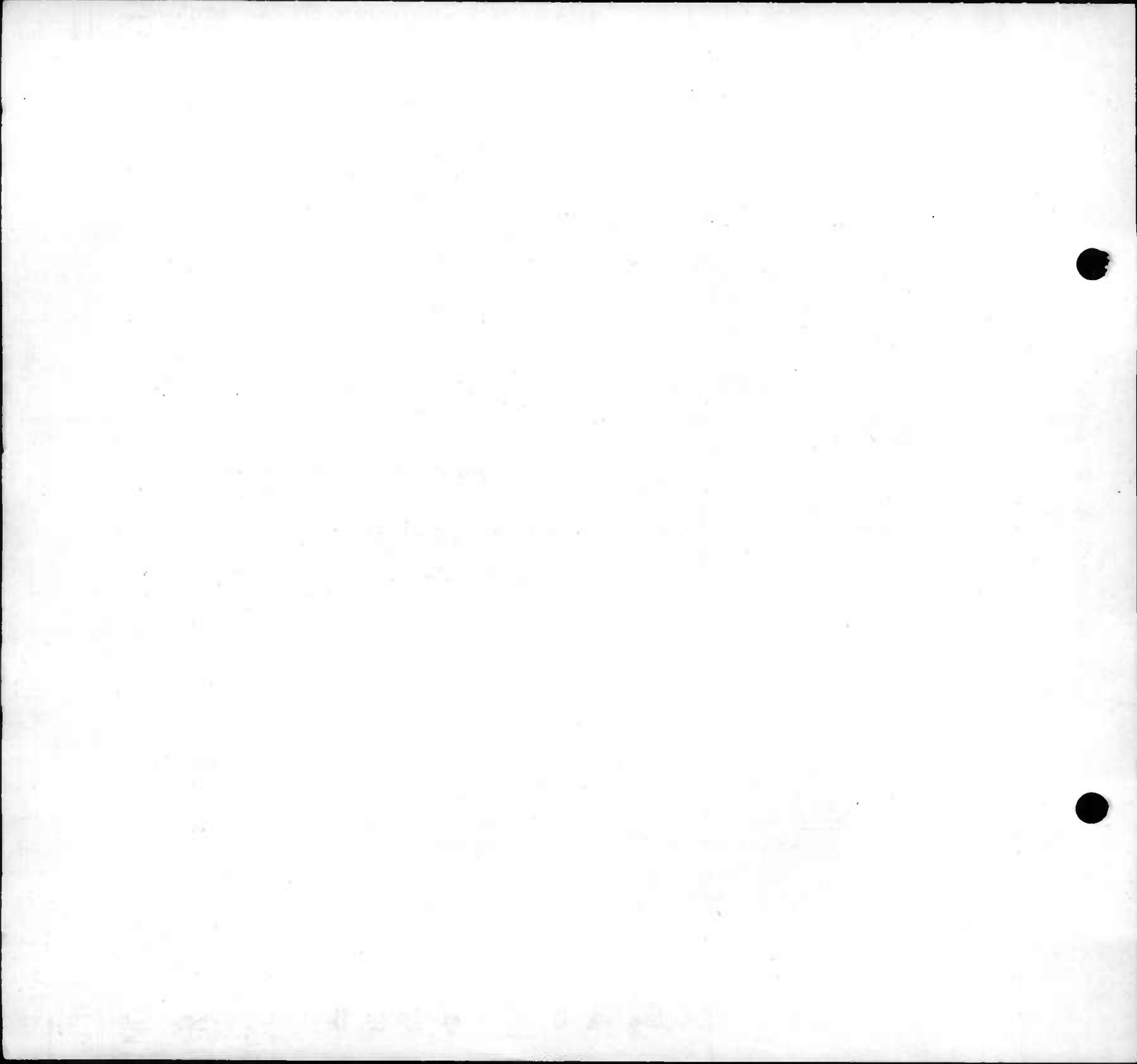
R-200 BIRTH NO.		69 12243 BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH REG. NO.		69 12243		
1. NAME OF DECEASED (Type or Print) Margaret M. Reese				2. DATE AND HOUR OF DEATH Dec. 9, 1969 12:00 AM				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 90 Harbor View Nursing Home				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2301				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
				E. STREET AND NUMBER 5 W. Ostend St.				
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1889	9. AGE (In years last birthday) 80	If Under 1 Yr. Months Days			If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Balto. Md.			12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Unknown Miller			14. MOTHER'S MAIDEN NAME Unknown Unknown					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT Family ADDRESS Same			
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Cordine Standstill Antecedent Causes DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Art. Sel. C-V Dis Gen. Ar. Sel. Secondary Anemia Rheumatoid Arthritis				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 6 hrs.				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II								
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 12/8 1969 to 12/9 1969 , that (I) (we) last saw the deceased alive on 12/8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.								
23A. SIGNATURE Kenneth Krulovitz				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/10/69		
23C. PHYSICIAN'S NAME (Type) Kenneth Krulovitz MD				23D. ADDRESS 115 W. Monument St. Balto MD				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 12 69		24C. NAME OF CEMETERY or CREMATORY Holy Cross		24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969				25B. NAME OF REGISTRAR Robert E. Kelly		25C. FUNERAL DIRECTOR Mc Gully ADDRESS 130 E. Fort AV		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

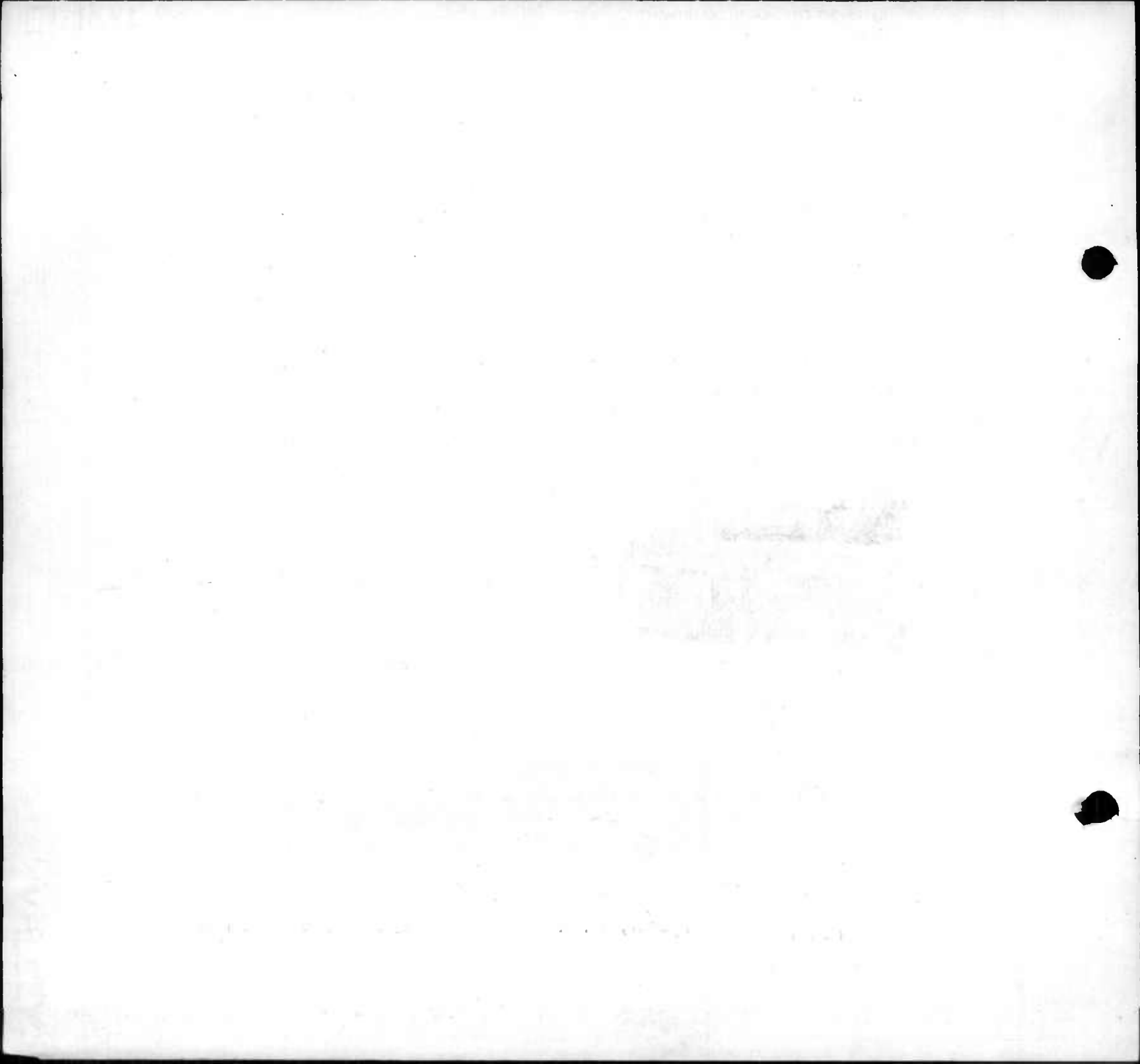
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12244	
BIRTH NO. D-120		69 12244		CERTIFICATE OF DEATH	
1. NAME OF DECEASED <small>(Type or Print)</small> William Davis			2. DATE AND HOUR OF DEATH 12-9-69 10:55 P.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <small>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</small> University of Maryland Hospital			4. USUAL RESIDENCE <small>(Where deceased lived. If institution: residence before admission)</small> A. STATE Maryland B. COUNTY 1509 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2506 Chelsea Terrace		
5. SEX m	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/24/79	9. AGE <small>(In years last birthday)</small> 90	10. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> Retired
10A. USUAL OCCUPATION <small>(Give kind of work done during most of working life, even if retired)</small> Retired		10B. KIND OF BUSINESS OR INDUSTRY Gardener		11. BIRTHPLACE <small>(State or foreign country)</small> Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.			13. FATHER'S NAME John Davis		
14. MOTHER'S MAIDEN NAME ?			15. Was Deceased Ever in U. S. Armed Forces? <small>(Yes, no or unknown) (If yes, give war or dates of service)</small> ?		
16. SOCIAL SECURITY NO. 217-05-6083A			17. INFORMANT Marcellus Carey (son) ADDRESS same		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <small>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</small> 412.4 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> (A) IMMEDIATE CAUSE ASPIRATION PNEUMONIA <small>DUE TO, OR AS A CONSEQUENCE OF:</small> (B) CHRONIC BRAIN SYNDROME <small>DUE TO, OR AS A CONSEQUENCE OF:</small> (C) A.S.C.V.D. </div> <div style="width: 35%; text-align: center;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?? ?? ?? </div> </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? <small>(Yes or No)</small> YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH <small>(notify medical examiner)</small>		21B. PLACE OF INJURY <small>(e.g., in or about home, farm, factory, street, office bldg., etc.)</small>		21C. WHERE DID INJURY OCCUR? <small>(If in Baltimore City, give exact location)</small>	
21D. TIME OF INJURY <small>(Approx.)</small>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/9 19 69 to 12/9 19 69, that (I) (we) last saw the deceased alive on 12/9 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William L. Boddie, M.D.				23B. DATE SIGNED 12/9/69	
23C. PHYSICIAN'S NAME <small>(Type)</small> William L. Boddie M.D.				23D. ADDRESS University of Maryland Hospital	
24A. BURIAL CREMATION, REMOVAL <small>(Specify)</small> Burial		24B. DATE 12/13/69		24C. NAME OF CEMETERY OR CREMATORY Union Chapel Cemetery	
24D. LOCATION <small>(City, town, or county)</small> Monkton Maryland		24E. STATE <small>(State)</small>			
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Adolphus Alstead ADDRESS 1206 W north Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-530		69 12245		BALTIMORE CITY HEALTH DEPARTMENT		69 12245	
BIRTH NO.		REG. NO.		69 12245		69 12245	
1. NAME OF DECEASED (Type or Print) <u>Ellie F. Smith</u>				2. DATE AND HOUR OF DEATH <u>December 10, 1969 8:55 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>George Washington Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1304</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>George Washington Nursing Home</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>Negro</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>July 14, 1883</u> 9. AGE (In years last birthday) <u>86 yrs.</u>		10. AGE (In years last birthday) <u>86 yrs.</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Calvert Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co.</u>	
13. FATHER'S NAME <u>Thomas Harvey</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Diggs</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>Chart # 506</u>		17. INFORMANT <u>607 Penn. Ave.</u>	
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>ARTERIOSCLEROTIC CARDIAC DISEASE</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Generalized Arteriosclerosis</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized Arteriosclerosis</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>26 APR 1969</u> to <u>10 Dec 1969</u> , that (1) (we) last saw the deceased alive on <u>5 Dec 1969</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Richard Tyson, M.D.</u>				23B. DATE SIGNED <u>11 Dec 69</u>			
23C. PHYSICIAN'S NAME (Type) <u>Richard Tyson, M.D.</u>				23D. ADDRESS <u>2320 Eutaw Place</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/12/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Not Calvary Cemetery Baltimore Md</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REGISTERED BY HEALTH DEPT. <u>DEC 11 1969</u>		25B. NAME OF REGISTRAR <u>E. J. Kelly, Jr.</u>		25C. FUNERAL DIRECTOR <u>Alvin McGinnis</u>		25D. ADDRESS <u>2302 W. North Ave.</u>	



H-350

69 12246

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12246

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charleton V. Hutton		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1100 Mt. Holly St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 8 69 5:40 p. m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1608	
9. DATE OF BIRTH 1/9/1889		10. AGE (In years lost birthday) 80	
11. BIRTHPLACE (State or foreign country) Chicago, Illinois		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas P. Hutton		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter	
15. MOTHER'S MAIDEN NAME Ellen Leigh		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 212-18-0711		18. INFORMANT ADDRESS Mrs. Herbert Reese-Bartlesville, Okla.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner	
DATE SIGNED 12/9/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/69	
24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Fairbank	
25C. FUNERAL DIRECTOR Robert C. Altenburg		ADDRESS Funeral Home, Inc. 6002 Harford Rd. - Balto., Md. 21214	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12247
69 12247 CERTIFICATE OF DEATH				REG. NO. 69 12247
BIRTH NO.				
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
MABEL A. MILBURN		12/10/69		0040 M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS 33		A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2032 PENROSE AVE		
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-10-21	9. AGE (In years last birthday) 48
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME THOS. ANDERSON		14. MOTHER'S MAIDEN NAME ANNIE BROWN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT MATHEW MILBURN-2032 PENROSE AVE
18. CAUSE OF DEATH 442 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) POST-OPERATIVE CONDITION (C) CEREBRAL ANEURYSM		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 MIN 4 WKS UNK. 2 WKS.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). RENAL FAILURE, PNEUMONIA				
19A. DATE OF OPERATION 11/18/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CEREBRAL ANEURYSM		20A. AUTOPSY? (Yes or No) NO
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11/14/69 to 12/10/69, that (I) (we) last saw the deceased alive on 12/10/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE W.L.M.		23B. DATE SIGNED 12/10/69		
23C. PHYSICIAN'S NAME (Type) WEI-H L. MD		23D. ADDRESS JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/69		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn
24D. LOCATION (City, town, or county) (State) Balto. Md.				
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Gable, R.D.		25C. FUNERAL DIRECTOR John A. Blatman, Jr. - 1701 Mt. Culloden St. Balto. Md.

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FUNERAL DIRECTOR: IMPORTANT

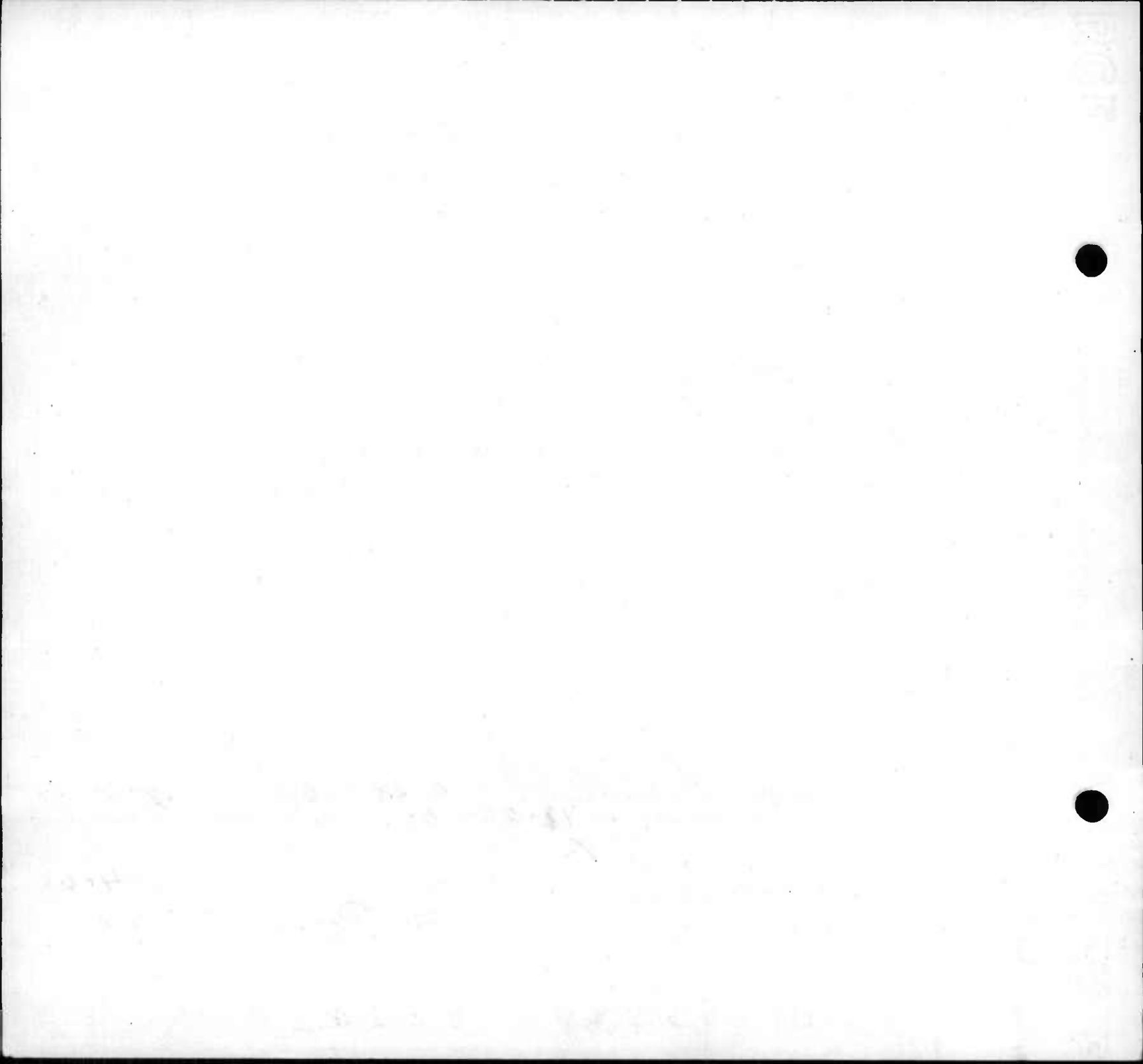
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-2521

BALTIMORE CITY HEALTH DEPARTMENT
69 12248 CERTIFICATE OF DEATH

REG. NO. 69 12248

BIRTH NO. 69 12248		2. DATE AND HOUR OF DEATH Dec 3, 1969 11:40 A.M.	
1. NAME OF DECEASED (Type or Print) Eva Washington		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1606	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland Baptist Home 90 2801 Rayner Ave		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE C 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 4 1893 9. AGE (In years last birthday) 76	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) S. C. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Maryland Baptist Home		ADDRESS 2801 Rayner Ave	
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH A. S. H. D. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (nately medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-28-1969 to 12-3-1969, that (I) (we) last saw the deceased alive on 12-29-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert Calin		23B. DATE SIGNED 12-4-69	
23C. PHYSICIAN'S NAME (Type) BARBU CALIN		23D. ADDRESS 831 Poplar Grove	
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 12/8/69	
24C. NAME OF CEMETERY or CREMATORY Balt Nat		24D. LOCATION Balt Md	
25A. DATE REC'D BY HEALTH DEPT DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Talley	
25C. FUNERAL DIRECTOR Joseph E. Rina		ADDRESS 2222 W. North Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]	
S-322 69 12249		69 12249	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>Stokes, William</i>		11-25-69 7:35 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View R. C. C.</i>		A. STATE <i>MD</i>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1213 Light Street. City 30</i>		B. COUNTY <i>1510</i>	
		C. CITY OR TOWN <i>Baltimore</i>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>4012 Main Street</i>	
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-16-00</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	9. AGE (In years last birthday) <i>69 yrs.</i>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-12-6555</i>	
		17. INFORMANT ADDRESS	
18. <i>436.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebro Vascular Accident</i> (B) <i>Generalized Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (this hospital) attended the deceased from <i>10/3/1969</i> to <i>Nov 25 1969</i> , that (we) last saw the deceased alive on <i>Nov 25 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (do not) view the body after death.			
23A. SIGNATURE <i>Adoracino B. Paulino</i>		23B. DATE SIGNED <i>Nov. 25, 1969</i>	
23C. PHYSICIAN'S NAME (Type) <i>Adoracino B. Paulino</i>		23D. ADDRESS <i>1213 Light St.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>11/9/69</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Wm. Anderson Cms</i>
24D. LOCATION (City, town, or county) (State) <i>1712 N. North Ave</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 11 1969</i>	
25B. NAME OF REGISTRAR <i>Robert E. Fisher, M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Robert E. Carroll</i>	



T-520

69 12250

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12250

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) HAZEL THOMAS Lillie		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 9, 1969 5:20 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 4/27/1910		10. AGE (in years last birthday) 59	
11. BIRTHPLACE (State or foreign country) Durham, N. Caroline		12. CITIZEN OF USA COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser		14B. KIND OF BUSINESS OR INDUSTRY Laundry	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 217-01-2738	
18. INFORMANT Mrs Ella Ford		ADDRESS 2207 Brookfield Ave	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Cardiovascular Disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/10/69			
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 12/13/69	
24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. 11-11-1969		25B. NAME OF REGISTRAR 22 E. Feb 4 1970	
25C. FUNERAL DIRECTOR 3710 Canal		ADDRESS 1712 W. North	

NOT EXAMINED WITHOUT ORDER OF DEATH

4/27/1910

James H. Coxworth USA

1st Lt

2nd of 2nd Regt Ala Cav

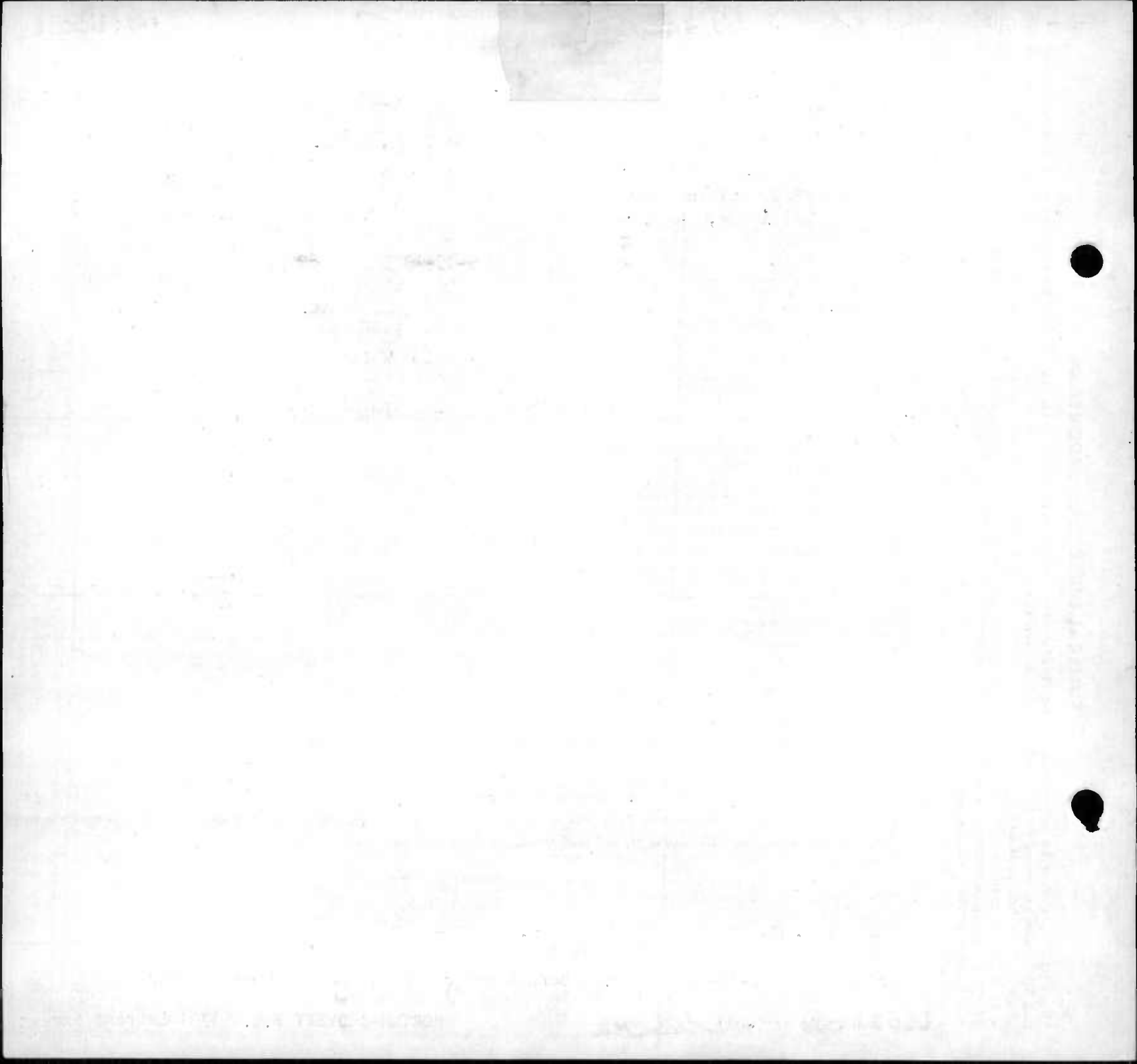
ACADEMIC BOARD

James H. Coxworth
4/27/1910

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-300		69 12251		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO.		69 12251	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>MARTHA SCOTT</u>				2. DATE AND HOUR OF DEATH <u>DECEMBER 8, 1969 10:10 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland, Baltimore</u> B. COUNTY <u>5300</u>				C. CITY OR TOWN <u>BALTIMORE</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>31</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE CITY HOSPITALS</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>543 New Pittsburgh Avenue 21222 005</u>		5. SEX <u>Female</u>				6. RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>9-15-1909</u>		9. AGE (In years last birthday) <u>60</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Disability</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia, Clover</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Alex Scott</u>				14. MOTHER'S MAIDEN NAME <u>Jennie White</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>021-18-7453</u>		17. INFORMANT <u>BCH-Records Baltimore, Maryland 21224</u>				ADDRESS <u>4940 Eastern Avenue</u>	
18. <u>412.4</u>		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CEREBROVASCULAR ACCIDENT</u>				<u>MINUTES</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>				<u>YEARS</u>			
(C) _____		(D) <u>RHEUMATIC HEART DISEASE</u>				<u>UNKNOWN</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (1) (this hospital) attended the deceased from <u>August 7, 1969</u> to <u>DECEMBER 8, 1969</u> , that (1) (we) last saw the deceased alive on <u>DECEMBER 8, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Michael M. McConnell, M.D.</u>		23B. DATE SIGNED <u>12-8-69</u>		23C. PHYSICIAN'S NAME (Type) <u>Michael M. Mc Connell</u>		23D. ADDRESS <u>BCH- 4940 Eastern Avenue Baltimore, Maryland 21224</u>		23E. FURNAL DIRECTOR ADDRESS <u>MORTON & DYETT F.H. 1701 Laurens Street</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-13-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 11 1969</u>	
25B. NAME OF REGISTRAR <u>J. E. Farley, M.D.</u>		25C. FURNAL DIRECTOR		25D. FURNAL DIRECTOR		25E. FURNAL DIRECTOR		25F. FURNAL DIRECTOR	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-355		69 12252		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12252	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) LINWOOD GOODMAN				2. DATE AND HOUR OF DEATH 12-9-69 5 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1509			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 PLEASANT MANOR NURSING HOME 4615 Park Heights Avenue				C. CITY OR TOWN Balto		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX M 6. RACE C 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 4-9-23		9. AGE (In years last birthday) 46	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cement Finisher				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Timmonsville, S.C.	
13. FATHER'S NAME James Goodman				14. MOTHER'S MAIDEN NAME Illhois Sanders			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO.				16. SOCIAL SECURITY NO. 250-28-4706		17. INFORMANT ADDRESS Mrs. Luvenia E. Goodman	
18. 199.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Metastatic Undifferentiated carcinoma ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Undifferentiated carcinoma (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION 09/25/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Breast Laminectomy		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (this hospital) attended the deceased from 11-24 1969 to 12-9 1969 , that (I) (we) last saw the deceased alive on 12-7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Frank G. Kuehn				DEGREE <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-9-69	
23C. PHYSICIAN'S NAME (Type) FRANK G. KUEHN				23D. ADDRESS 721 Med Arts Bldg.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/69		24C. NAME OF CEMETERY OR CREMATORY Arbatus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR John E. Jones, Jr.		25C. FUNERAL DIRECTOR W. R. and D. J. Laurens		ADDRESS 1701	

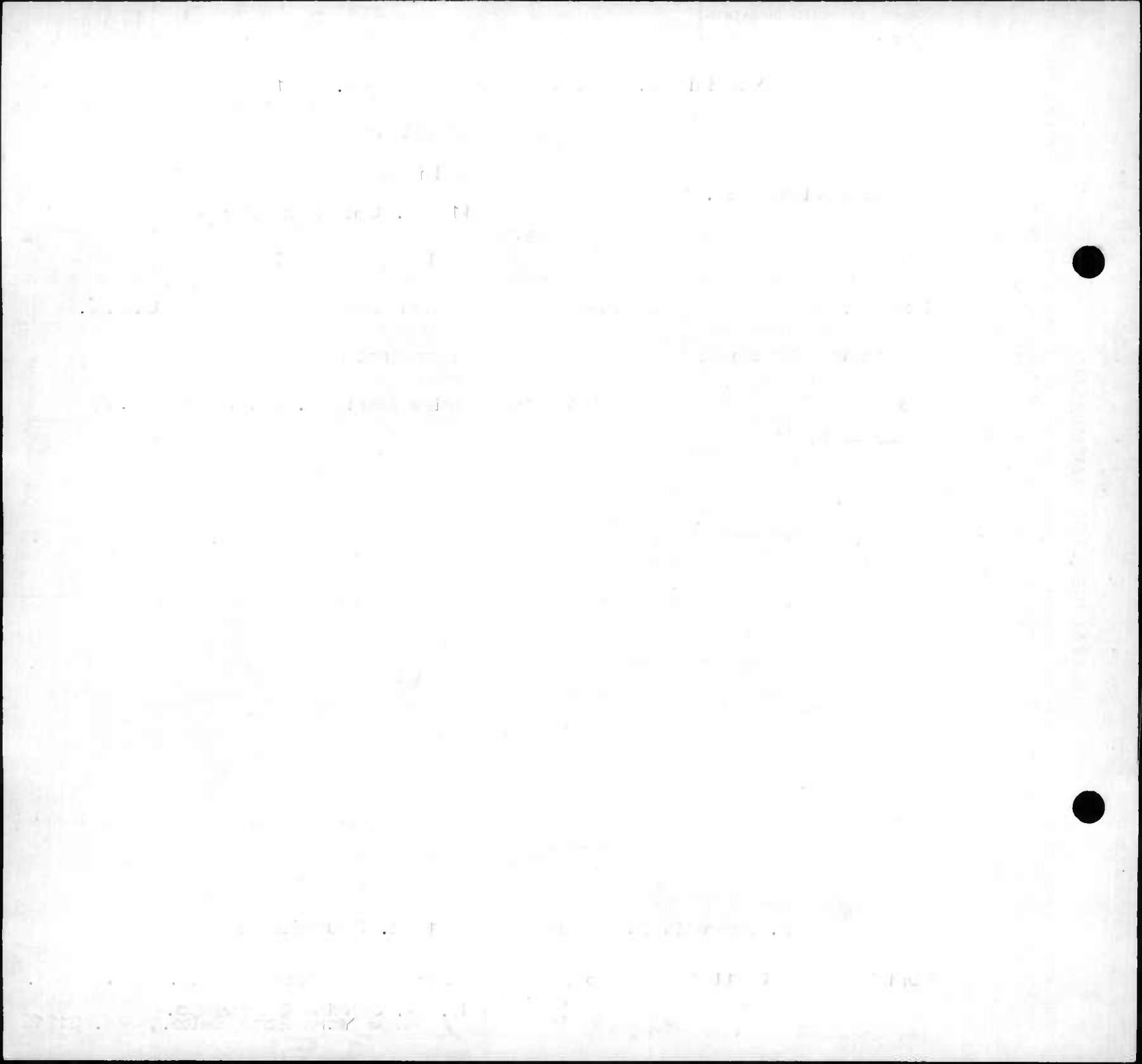
11/11
10/11
10/11

C M

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

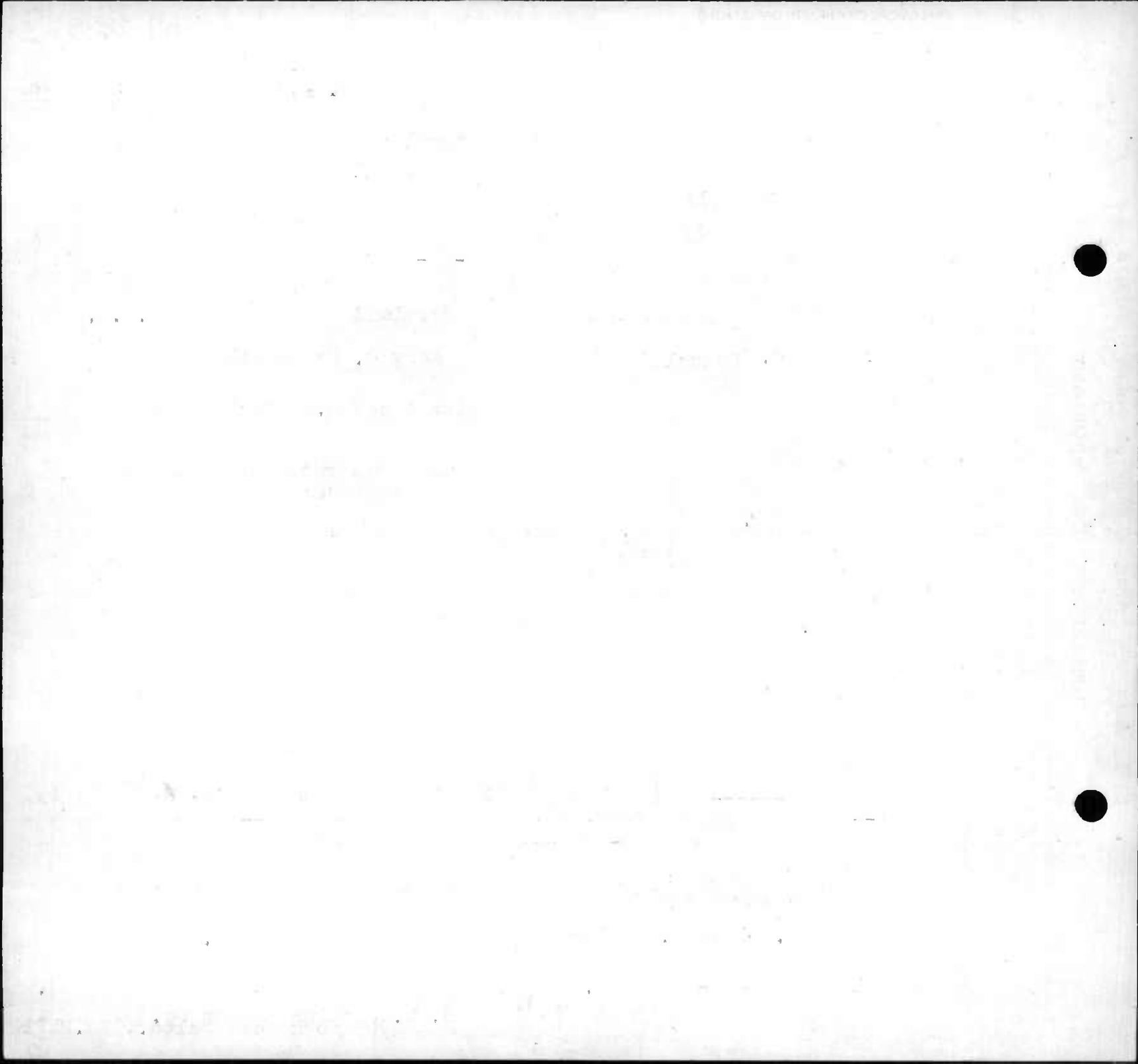
<div style="display: flex; justify-content: space-between;"> B-423 69 12253 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 69 12253 </div>	
BIRTH NO. 1 1. NAME OF DECEASED (Type or Print) 2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> Virginia C. Blackhead Dec. 9, 1969 4:25P M. </div>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Broadview Apts.	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 1201 C. CITY OR TOWN D. INSIDE CITY LIMITS? Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 116 W. University Parkway	
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-1882 9. AGE (In years lost birthday) 87 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 10B. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Matthew Blackhead 14. MOTHER'S MAIDEN NAME Margaret Ray	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No 16. SOCIAL SECURITY NO. 220-44-7320 17. INFORMANT Miss Marie C. Remmert ADDRESS Same	
18. 440.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Pruritic Arteriosclerosis</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 yrs	
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from 19 46 to Dec 9 19 69, that (I) (we) last saw the deceased alive on Dec 8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <i>Franklin E. Leslie</i> DEGREE 23B. DATE SIGNED 12-10-69 23C. PHYSICIAN'S NAME (Type) Dr. Franklin E. Leslie 23D. ADDRESS 3501 St. Paul Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-11-1969 24C. NAME OF CEMETERY or CREMATORY Woodlawn Cemetery 24D. LOCATION (City, town, or county) (State) Woodlawn Balto., Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969 25B. NAME OF REGISTRAR <i>James J. [illegible]</i> 25C. FUNERAL DIRECTOR <i>James J. [illegible]</i> ADDRESS 4909 York Road Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

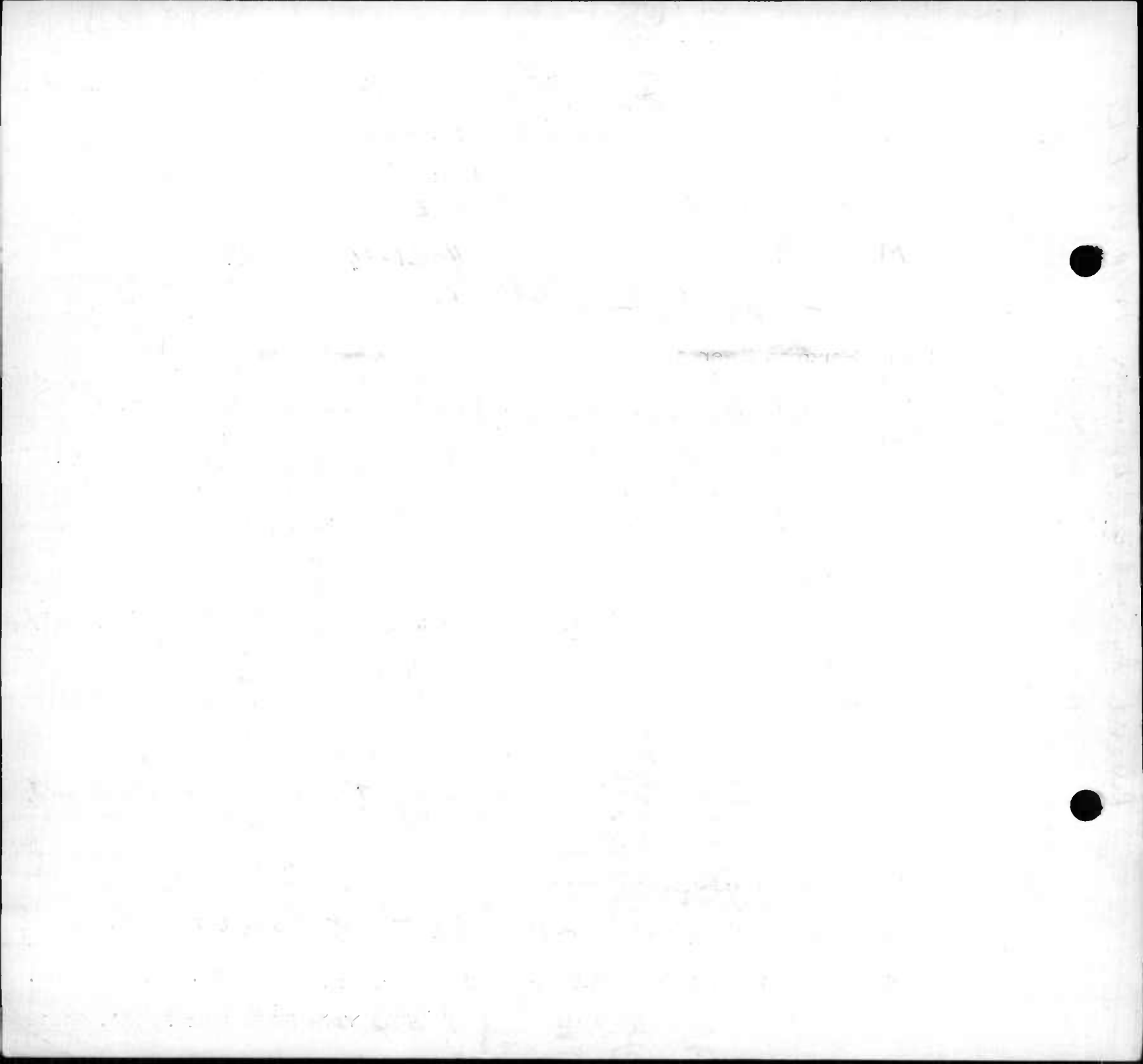
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12254
C-300		69 12254		CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
		Anne Lenora Codd		Dec. 8, 1969 12:00 Noon M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		
		B. COUNTY		
00 304 Birkwood Place		C. CITY OR TOWN		D. INSIDE CITY LIMITS?
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER		
		304 Birkwood Place		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
F	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	5-24-1890	79
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Homemaker		Own Home		Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
Patrick N. Connell		Mary D. McDonnell		U.S.A.
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT
No				Miss Agnes E. Connell
				ADDRESS
				Same
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF		
		Arteriosclerotic cardio-vascular disease		
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
0				No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from November 1964 to Dec. 8, 1969, that (I) (we) last saw the deceased alive on Nov. 17, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE				23B. DATE SIGNED
Lloyd E. Saylor				Dec. 9, 1969
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		
Dr. Lloyd E. Saylor		3902 Greenmount Ave.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY
Burial		12-11-1969		St. Joseph Cemetery, Texas, Md.
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR
DEC 11 1969		H. W. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Z-624		69 12255		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12255	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) WALTER R. ZWERGEL				2. DATE AND HOUR OF DEATH 12-10-69 12:21 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 44 UNION MEMORIAL HOSP.				A. STATE MARYLAND.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY 1202			
C. CITY OR TOWN BALTIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 10 E. 33rd Street							
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-21-16	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STATISTICIAN		10B. KIND OF BUSINESS OR INDUSTRY UNIV. OF MD. HOSPITAL		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry Hartman Zwergel				14. MOTHER'S MAIDEN NAME Maydelind			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWII				16. SOCIAL SECURITY NO. 109-01-6374		17. INFORMANT EDWARD J. FRANK	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.31				CAUSE OF DEATH (A) IMMEDIATE CAUSE PULMONARY EDEMA DUE TO, OR AS A CONSEQUENCE OF: 1 hour		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II				(B) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF: 4 years			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A) ① Hemiplegia						8 months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December 9, 1969 to December 10, 1969 , that (I) (we) last saw the deceased alive on December 10, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Enrique Cipriani M.D.						23B. DATE SIGNED 12-10-69	
23C. PHYSICIAN'S NAME (Type) ENRIQUE CIPRIANI M.D.						23D. ADDRESS 33rd & Calvert Sts.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-1969		24C. NAME OF CEMETERY or CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Harry W. Jenkins		25C. FUNERAL DIRECTOR Harry W. Jenkins & Sons Co.		ADDRESS 2905 York Road Balto., Md. 21212	



69 12256

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12256

BIRTH NO.

1. NAME OF DECEASED (Type or Print) WILLIE BLAKE		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1007 E. Monument Street		3. DATE PRONOUNCED DEAD Month Day Year Hour December 4, 1969 3:25 A.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 501			
6. SEX Male	7. RACE Negro	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 7/13/	10. AGE (In years last birthday) 56	11. BIRTHPLACE (State or foreign country) South Carolina	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME William Blake	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Bell Nelson			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 240-12-3570	
18. INFORMANT Mrs Mattie Turner		ADDRESS 3142 Virginia Ave	
19. 412.2 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 4, 1969			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/10/69	
24C. NAME OF CEMETERY or CREMATORY Sanford		24D. LOCATION (City, town, or county) (State) North Carolina	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR 22. 12-3570, 22. 0 0 0	
25C. FUNERAL DIRECTOR Adolphus Halstead		ADDRESS 1206 W. north Ave	

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100-1-100-100

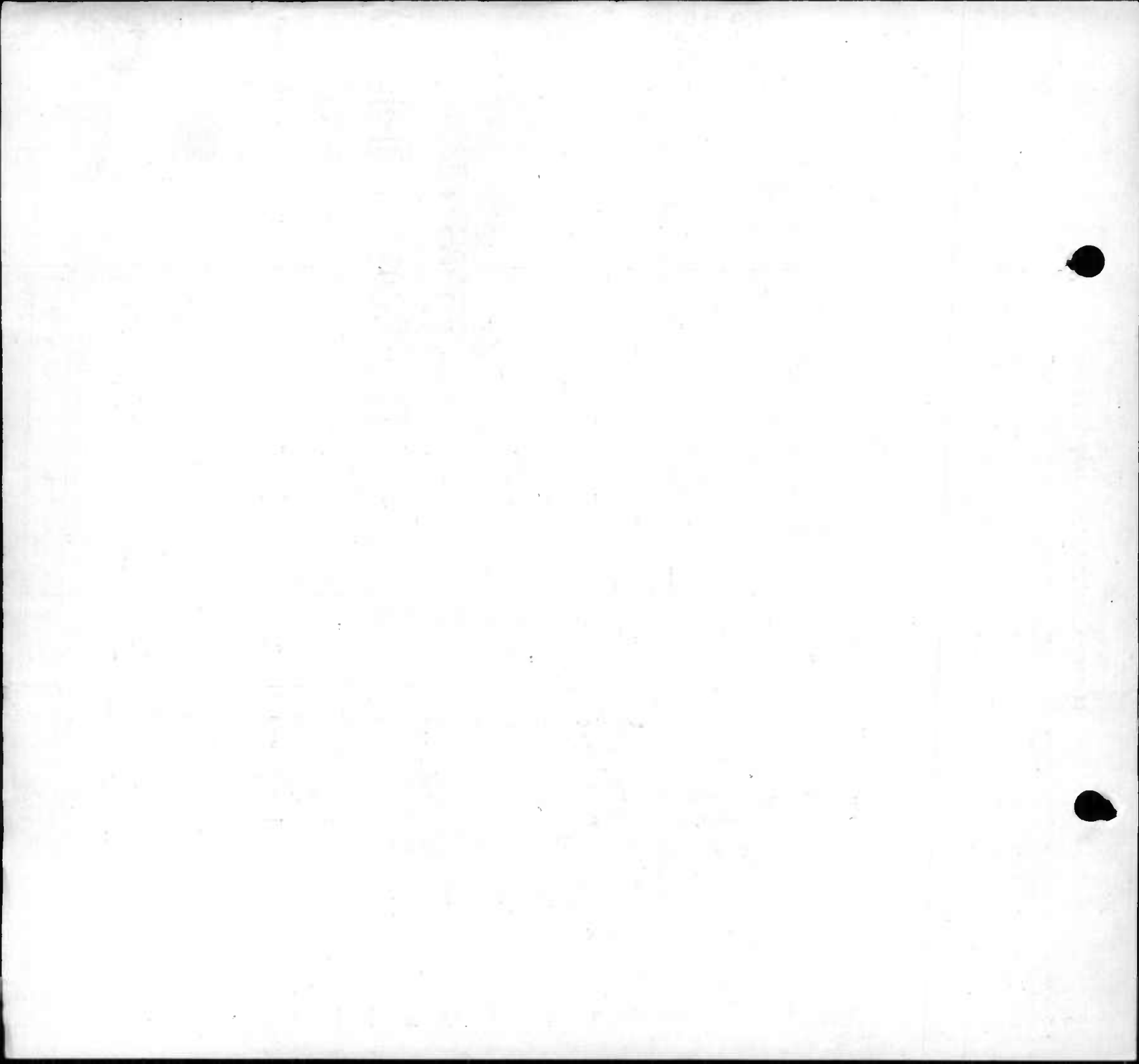
100-1-100-100

100-1-100-100

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

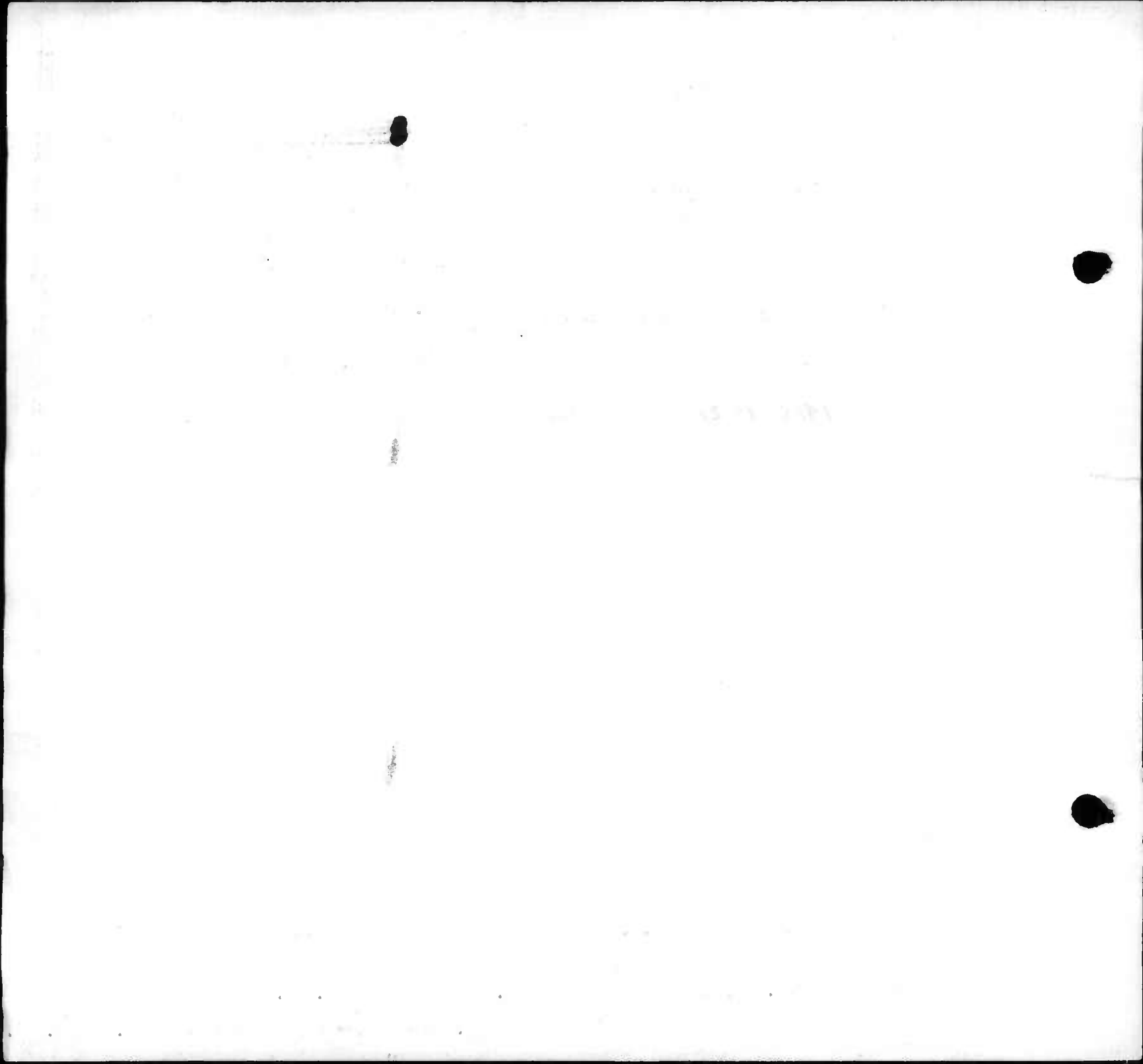
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12257	
W-520		69 12257		BIRTH NO.	
1. NAME OF DECEASED (Type or Print) ANNA WIENECKE			2. DATE AND HOUR OF DEATH December 8, 1969 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gould Convalesarium			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 102		
5. SEX Female			6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Jan. 19, 1873			9. AGE (In years last birthday) 96		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ? Witttestadt			14. MOTHER'S MAIDEN NAME ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Philip Wienecke, 2422 Kentucky Ave.
18. 412.31 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH Arteriosclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 1967 to DEC 7 1969, that (I) (we) lost saw the deceased alive on DEC 7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Melito M. Torres, M.D. DEGREE				23B. DATE SIGNED 12-9-69	
23C. PHYSICIAN'S NAME (Type) Melito M. Torres, M.D.				23D. ADDRESS 441 S. Ellwood Ave.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/69		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cemetery	
24D. LOCATION (City, town, or county) (State) Colgate, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969 Caleb E. Jones REGISTRAR			
25B. NAME OF REGISTRAR Caleb E. Jones				25C. FUNERAL DIRECTOR ADDRESS Uriah Funeral Home, 4210 Belair Road.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

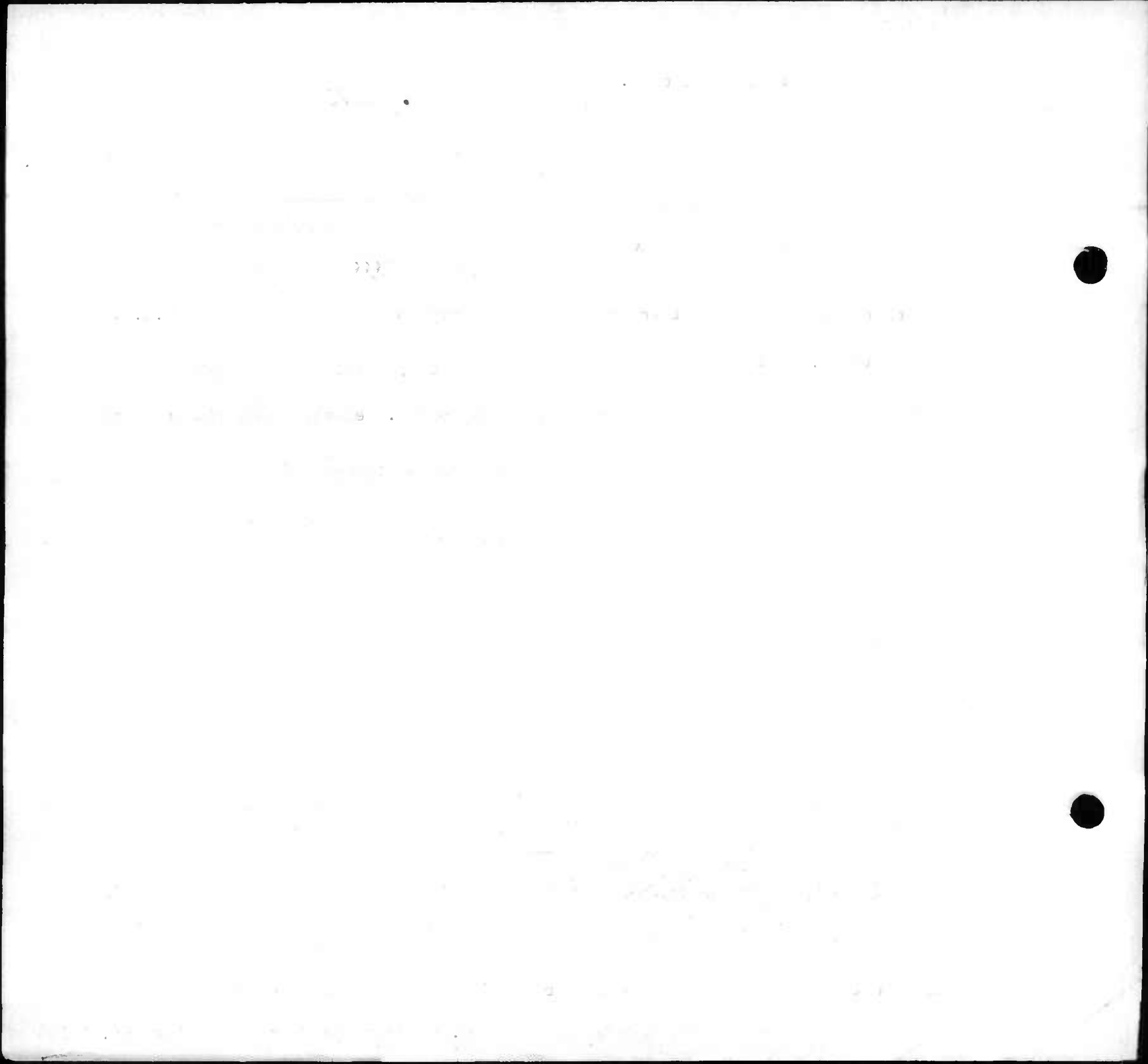
H-230 69 12258		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X	REG. NO. 69 12258
BIRTH NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) Clifford Hassett			12/8/69 11:35 a.m.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospital 4940 Eastern Avenue Baltimore, Maryland 21224			A. STATE Maryland B. COUNTY Baltimore CO. 5300		
5. SEX Male			6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3-3-1898		9. AGE (In years last birthday) 71		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist			10B. KIND OF BUSINESS OR INDUSTRY Eastern Stainless Steel		11. BIRTHPLACE (State or foreign country) Wiscousin
12. CITIZEN OF WHAT COUNTRY? United States			13. FATHER'S NAME John (dec.)		
14. MOTHER'S MAIDEN NAME Bessie (dec.) Hall			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) Yes 1918-1921		
16. SOCIAL SECURITY NO. 218-10-2595			17. INFORMANT BCH Records: Baltimore, Md. 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 519.2 I Chronic Obstructive Airway Disease 15 yrs			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/> Notify medical examiner			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/7/69 19 to 12/8 1969 that (I) (we) last saw the deceased alive on 12/8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William McDonald, M.D.				23B. DATE SIGNED 12/8/69	
23C. PHYSICIAN'S NAME (Type) William McDonald, M.D.				23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 11, 1969		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969			
25B. NAME OF REGISTRAR E. J. [unclear]		25C. FUNERAL DIRECTOR Truman Schwab			
25D. ADDRESS 3512 Frederick Ave.		Balto. Md.			



FUNERAL DIRECTOR: IMPORTANT

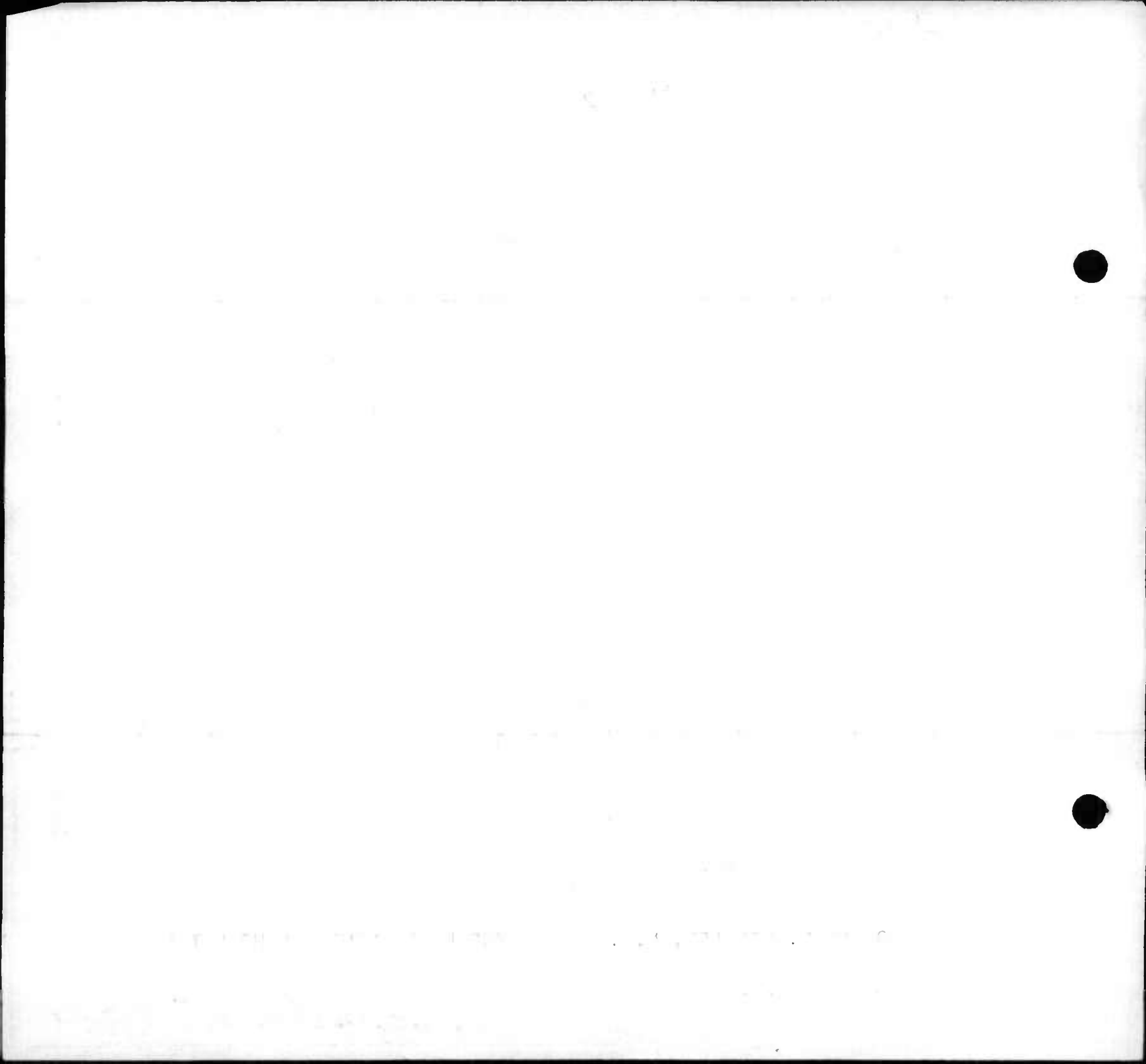
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-534		69 12259		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		69 12259	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) KENDALL, ETHEL				2. DATE AND HOUR OF DEATH 12/19/69 1:30A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION SINAI HOSPITAL OF BALTIMORE, INC.				A. STATE MD.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42				B. COUNTY BALTIMORE CITY 2730			
				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 4000 PINKNEY RD			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/23/1909	9. AGE (in years last birthday) 70	10. Under 1 Yr. Months	11. Under 24 Hrs. Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales clerk				10B. KIND OF BUSINESS OR INDUSTRY Hutzler's		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Walter B. Smith				14. MOTHER'S MAIDEN NAME Ida M. Blunt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-24-0877		17. INFORMANT Raymond V. Kendall	
				ADDRESS 4000 Pinkney Road			
18. 1538 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Widespread Metastases ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of colon (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos 2 mos	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that the (this hospital) attended the deceased from Dec 9, 1969 to Dec 10, 1969 that the (we) lost saw the deceased alive on Dec 10, 1969 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. The (We) (did) did not view the body after death.							
23A. SIGNATURE Gerald A. Hoffman, M.D.				23B. DATE SIGNED 12/10/69		23C. PHYSICIAN'S NAME (Type) GERALD A. HOFFMAN, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 12-13-1969		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF CONTRA		25C. FUNERAL DIRECTOR Wm. Cook-Brooks			
				ADDRESS Towson 1050 York Rd. 21204			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

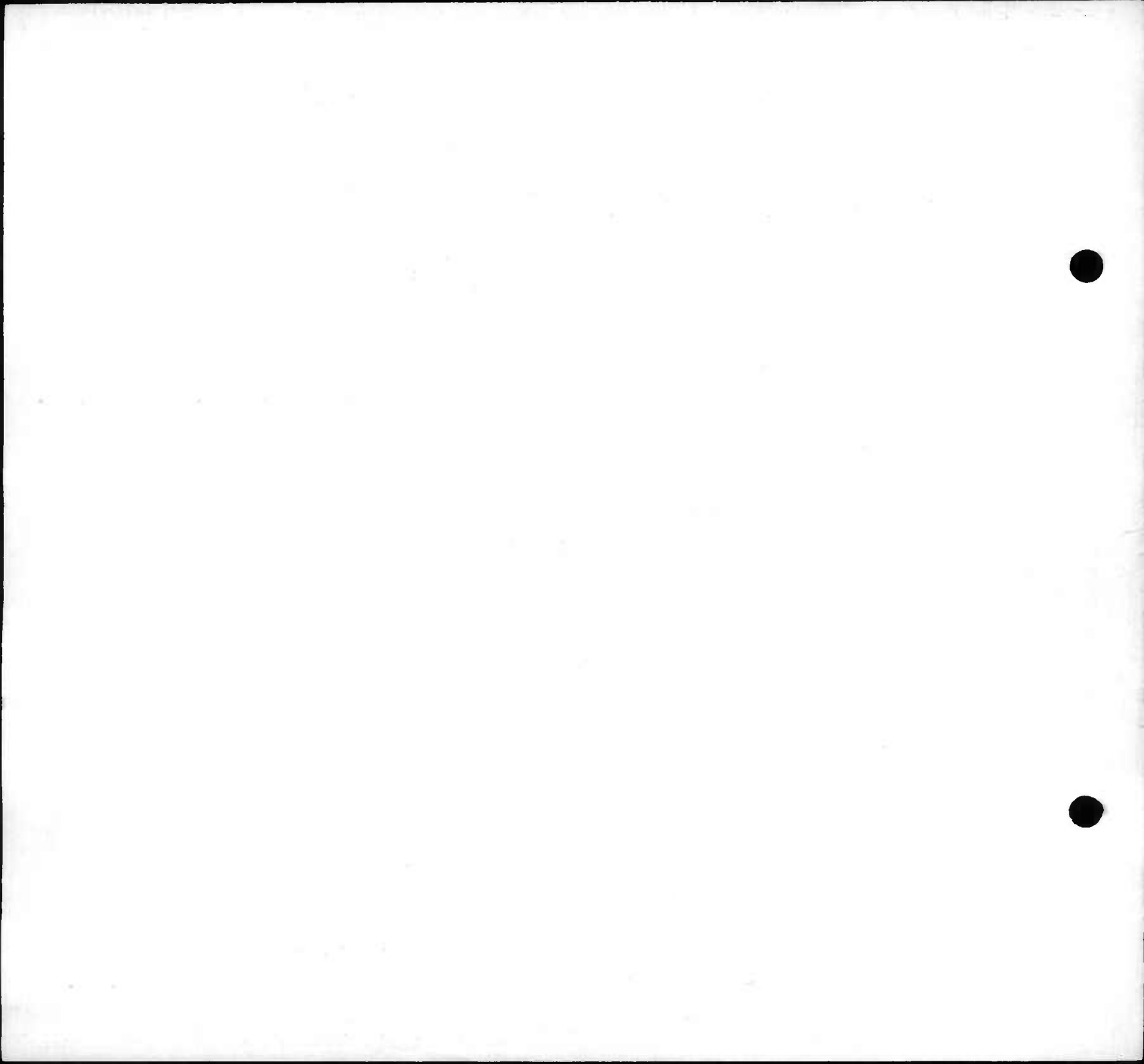
BALTIMORE CITY HEALTH DEPARTMENT		69 12260		69 12260	
BIRTH NO. 6-000		69 12260		REG. NO.	
1. NAME OF DECEASED (Type or Print) GOLDIE M GAY			2. DATE AND HOUR OF DEATH 8 12/3/69 8:30 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD 8. COUNTY 1204		
5. SEX F			6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk		10B. KIND OF BUSINESS OR INDUSTRY Cannon Shoe Co.		11. BIRTHPLACE (State or foreign country) Lewis Co. W. Va.	
13. FATHER'S NAME ? Robert W. Gay			14. MOTHER'S MAIDEN NAME ? Laura Canfield		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 232-09-2893		17. INFORMANT Forrest Henry Weston ADDRESS 266 Cottage Ave. Weston, W. Va.	
18. 432.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) (R) Internal Cancer CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: OCC. VASC. DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/2/69 to 12/3/69 that (I) (we) last saw the deceased alive on 12/3/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ronald M. Geckler			23B. DATE SIGNED 12/3/69		23C. PHYSICIAN'S NAME (Type) RONALD M. GECKLER, M.D.
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial			24B. DATE 12-7-1969		24C. NAME of CEMETERY or CREMATORY Weston Masonic
24D. LOCATION Weston, W. Va.			24E. ADDRESS Weston, W. Va.		
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR John E. Valley		25C. FUNERAL DIRECTOR Highinbotham S. K. F. H. Ellwood	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12261	
BIRTH NO. 69-22467				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
BABY BOY Behe				12/6/69 10 ⁰⁰ A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
BALTIMORE CITY HOSPITALS 4940 Eastern Ave., Baltimore, Md. 21224				MARYLAND BALTIMORE 5300	
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. UNDER 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
M CAUC				12/5/69 1 DAY 07 35	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)	
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY	
				MARYLAND US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
DAVID Behe					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
NO				NONE	
17. INFORMANT				ADDRESS	
BIRTH RECORDS				4940 Eastern Ave. Baltimore, Md. 21224	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				2-3 hrs	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				ASPIRIN - PROB INTRACRANIAL HEMORRHAGE	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DISMATUREITY DUE TO, OR AS A CONSEQUENCE OF: EARLY DELIVERY TRAUMATIC	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2 NONE		NONE		Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO		NONE		NONE	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
NONE				NONE	
22. I certify that (I) (this hospital) attended the deceased from Dec 5 1969 to Dec 6 1969 that (II) (we) last saw the deceased alive on Dec 6 1969 and that (a) (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Richard M. Thaler MD				12/6/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Richard M. Thaler MD				Baltimore City Hospitals 4940 Eastern Ave. BALTIMORE, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		12-9-69		BALTIMORE CITY HOSPITALS	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 11 1969		James E. Taylor		21224	
HOSPITAL DISPOSAL					



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-200 69 12262		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12262 4	
BIRTH NO. 69-21577		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Baby Girl Wanda Sisco</i>		2. DATE AND HOUR OF DEATH <i>11/22/69 11:07 a.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Baltimore City Hospitals 14940 Eastern Ave. Baltimore Md. 21224</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>md.</i> B. COUNTY <i>1512</i>			
5. SEX <i>Female</i> 6. RACE <i>NEGRO</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11/22/69</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (in years last birthday) <i>1</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>		13. FATHER'S NAME <i>Charles M. Sisco</i>	
14. MOTHER'S MAIDEN NAME <i>Wanda Miller</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>1</i>	
17. INFORMANT <i>BCH RECORDS Baltimore, Maryland 21224</i>		ADDRESS <i>4940 Eastern Avenue</i>		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 18. <i>740X I</i> <i>Respiratory arrest</i> <i>10 min</i> <i>Anencephaly</i> <i>?</i> <i>Congenital Deformity</i> <i>?</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/22</i> 19 <i>69</i> to <i>11/22</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>11/22</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>A.O. Roberts MD</i>		23B. DATE SIGNED <i>11/23/69</i>		23C. PHYSICIAN'S NAME (Type) <i>A.O. ROBERTS</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		24B. DATE <i>12-5-69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore City Hospitals</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 11 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Talley, Jr.</i>		25C. FUNERAL DIRECTOR <i>HOSPITAL DISPOSAL</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland 21224</i>		24E. ADDRESS <i>BALTIMORE CITY HOSPITALS 4940 EASTERN AVENUE, BALTIMORE, MARYLAND 21224</i>			

BCH gave 2923 Rockrose Ave.
as being correct address. ✓

T-160
BIRTH NO. 69-22263 12263
CERTIFICATE OF DEATH

REG. NO.

1. NAME OF DECEASED
(Type or Print)

TAUBER

BG (CHARLENZ)

2. DATE AND HOUR OF DEATH

11/30/69 1035 pm

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE B. COUNTY BALTIMORE MD. 5300

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐ NO ☒

E. STREET AND NUMBER

7917 Wise Ave 21222

5. SEX

Female

6. RACE

White

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

11/30/69

9. AGE (In years
last birthday)

5

If Under 1 Yr.
Months Days

5

If Under 24 Hrs.
Hours Min.

5

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

0

10B. KIND OF BUSINESS OR INDUSTRY

0

11. BIRTHPLACE (State or foreign country)

Baltimore MD.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Carl Tauber

14. MOTHER'S MAIDEN NAME

CHARLENZ Bauhman

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS
4940 Eastern Avenue
BCH: Records Baltimore, Maryland 21224

18. 5-19-21

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac arrest

(B) neonatal lung disease

DUE TO, OR AS A CONSEQUENCE OF:

(awaiting autopsy)

(C)

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

21E. INJURY OCCURRED

While At ☐ Not While
Work At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/30 545 pm 19 69 to 11/30 1025 pm 19 69
that (I) (we) last saw the deceased alive on 11/30 19 69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

C Krush

DEGREE

Attending ☒ Phys.Med.
Director ☐Staff ☐ Phys.

23B. DATE SIGNED

12/1/69

23C. PHYSICIAN'S
NAME (Type)

Carol Krush

DEGREE

23D. ADDRESS

4940 Eastern Avenue
Baltimore, Maryland 2122424A. BURIAL CREMATION,
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town, or county)

(State)

Cremation

12-2-69

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 11 1969

Robert E. Taylor, M.D.

0 0 0

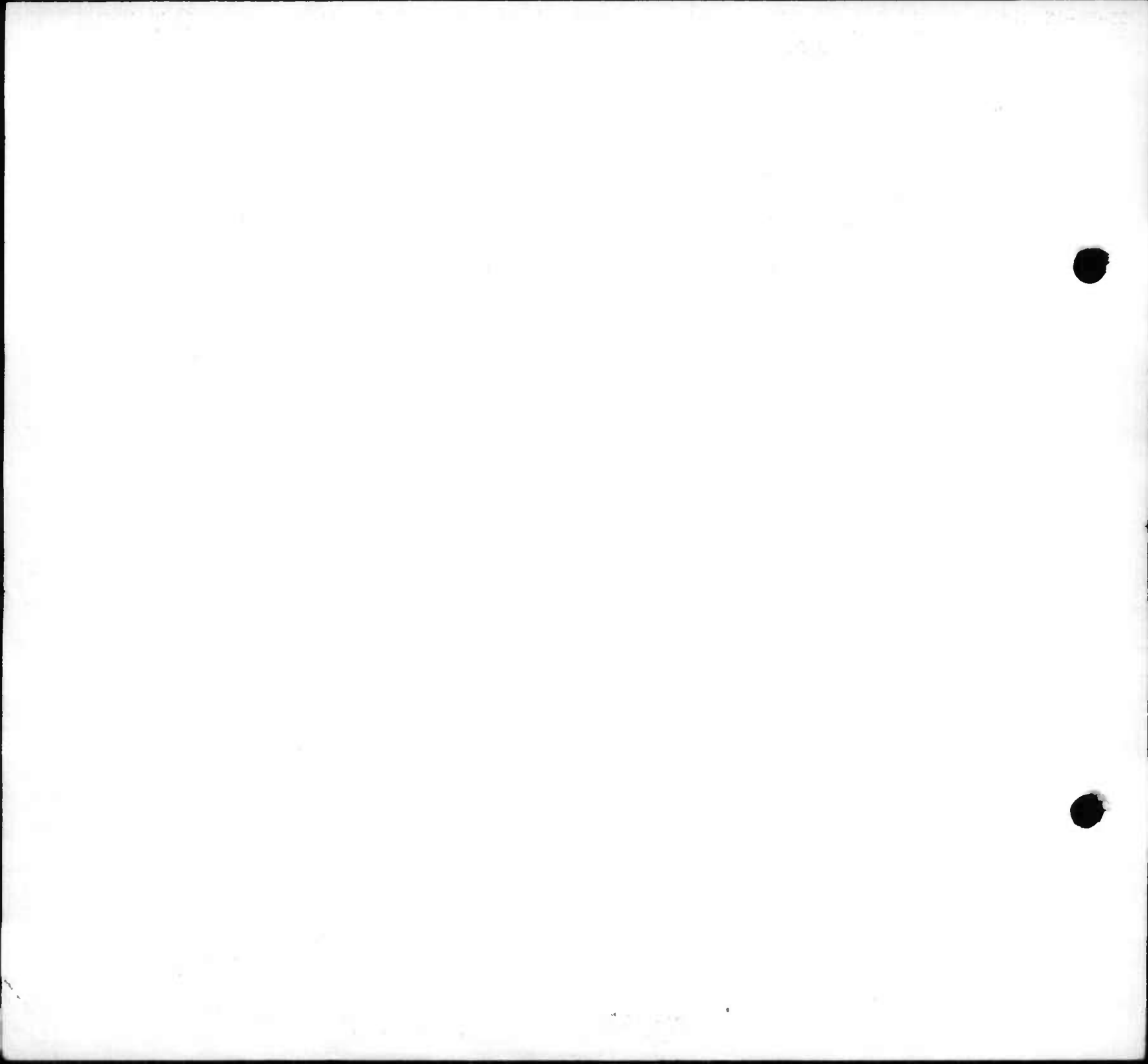
9

HOSPITAL DISPOSAL

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

55-74-071aj

R. 300

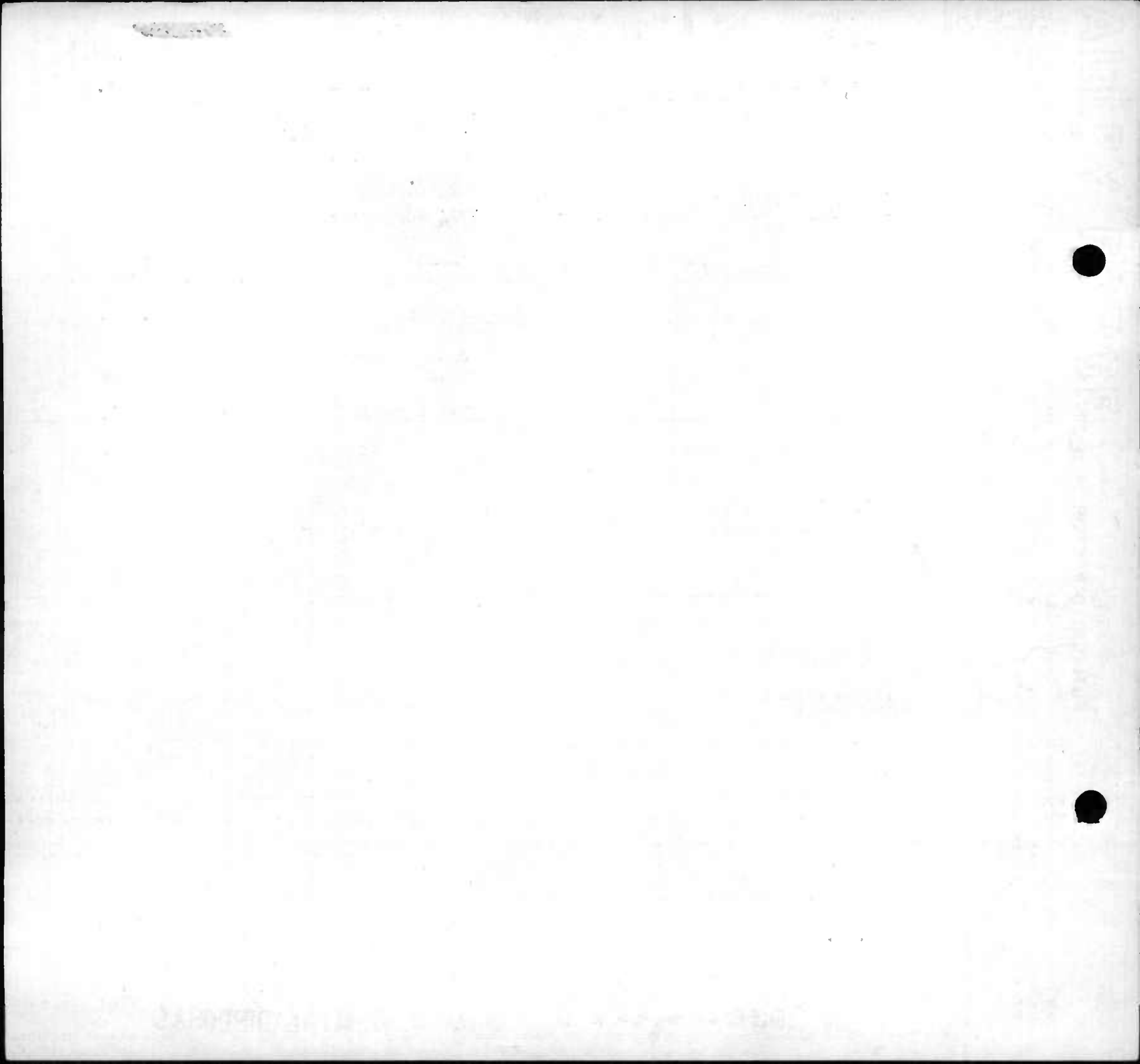
69 12264

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO. 69 12264

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

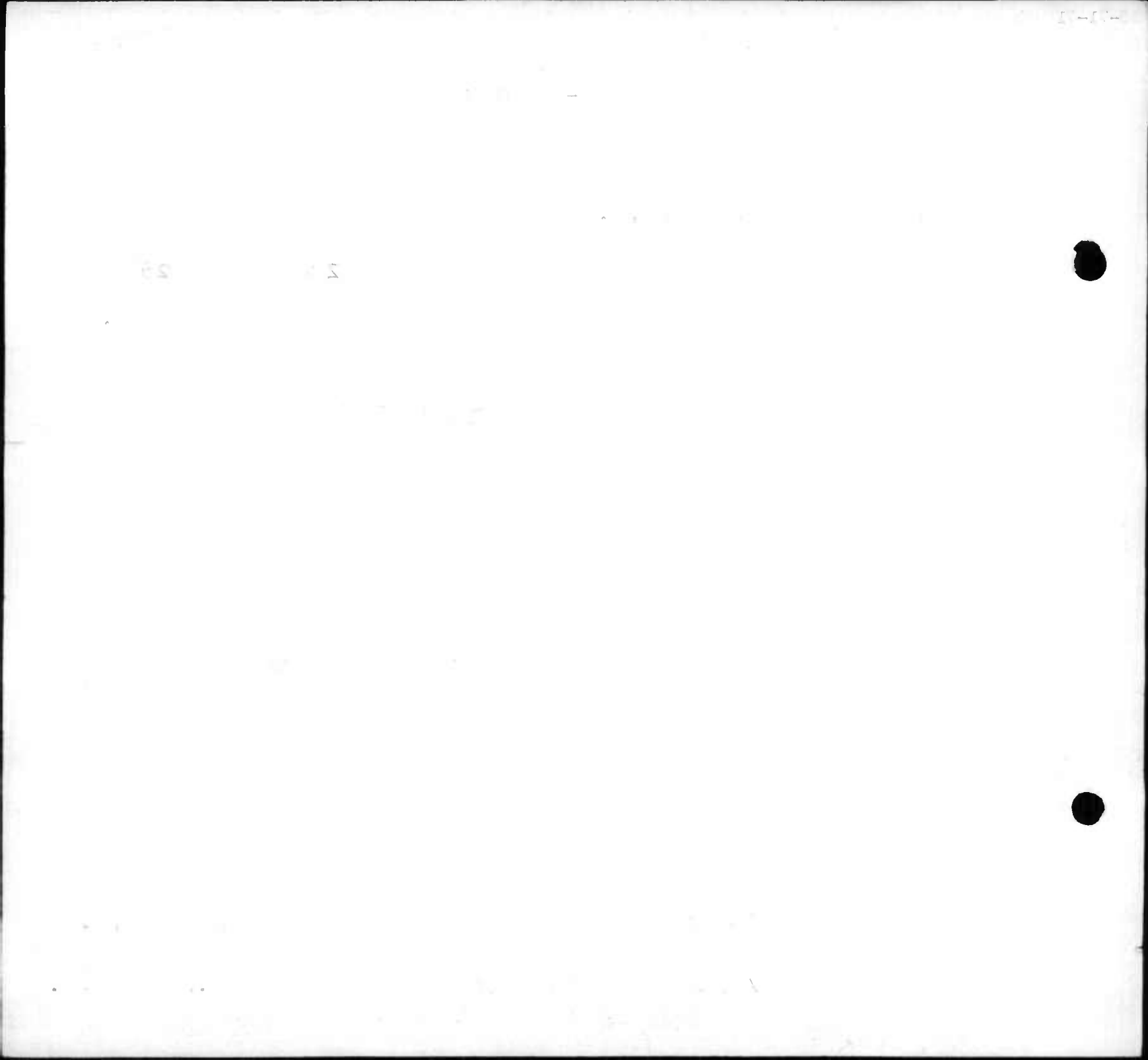
BIRTH NO. 69-24533		2. DATE AND HOUR OF DEATH 11-17-69 1:30 P.M.	
1. NAME OF DECEASED (Type or Print) Reed, Baby Girl, Judith		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY Baltimore	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 BALTIMORE CITY HOSPITALS 21224 4940 Eastern Avenue Baltimore, Maryland		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE Negro 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-4-69 9. AGE (In years lost birthday) 13	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Judith Reed	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT BCH: Records Baltimore, Maryland		ADDRESS 4940 Eastern Avenue 21216	
18. 77691 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Pulmonary Insufficiency of the Newborn 48 hrs. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Prematurity of birth		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-5-69 to 11-17-69, that (I) (we) lost saw the deceased alive on 11-17-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE G. W. Gragg, M.D.		23B. DATE SIGNED 11-18-69	
23C. PHYSICIAN'S NAME (Type) G. W. Gragg		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) CREMATION		24B. DATE 11-18-69	
24C. NAME OF CEMETERY OR CREMATORY Baltimore City Hospitals		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland 21224	
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR ADDRESS		25D. HOSPITAL DISPOSAL	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-520		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12265	
BIRTH NO. 69-20180		69 12265		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) FENWICK, BABY BOB JR Priscilla		2. DATE AND HOUR OF DEATH 11-27-69 11:45 P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 1403			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITAL 4940 Eastern Avenue, Baltimore, Md. 21224		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 512 BAKER ST 21217					
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-2-69	9. AGE (In years last birthday) 25 days	If Under 1 Yr. Months: Days 25 If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME PRISCILLA FENWICK		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records: BCH-4940 Eastern Avenue 21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). PREMATURE TWIN BILATERAL INGUINAL HERNIORRAPHY 11/26		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST (B) CEREBRAL ANOXIA DUE TO, OR AS A CONSEQUENCE OF: (C) POST OP CARDIORESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 11/26/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BILATERAL INGUINAL HERNIA		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/2/69 19 to 11/27 19 69 that (I) (we) last saw the deceased alive on 11/27/69 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE C Krush MD		23B. DATE SIGNED 11-28-69		23C. PHYSICIAN'S NAME (Type) Carol Krush MD	
23D. ADDRESS 4940 Eastern Avenue, Baltimore, Md.		23E. ADDRESS BALTIMORE CITY HOSPITAL 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremated		24B. DATE 11/28/69		24C. NAME OF CEMETERY or CREMATORY Baltimore City Hospitals	
24D. LOCATION 4940 Eastern Ave., Baltimore, Md.		24E. LOCATION (City, town, or county) 21224 (State)			
25A. DATE REC'D BY HEALTH DEPT. DEC 11 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR HOSPITAL DISPOSAL	

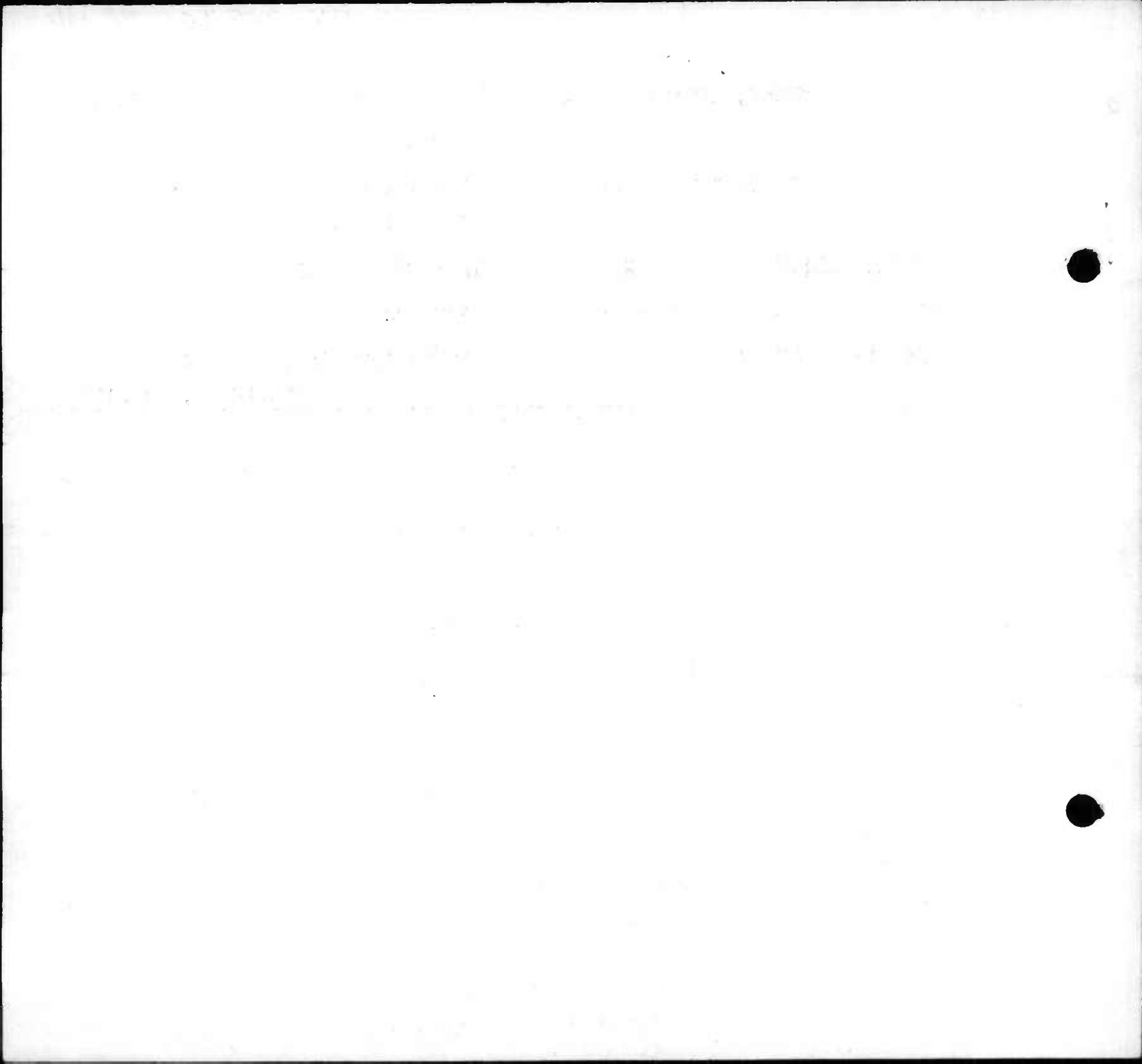


M-240 1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

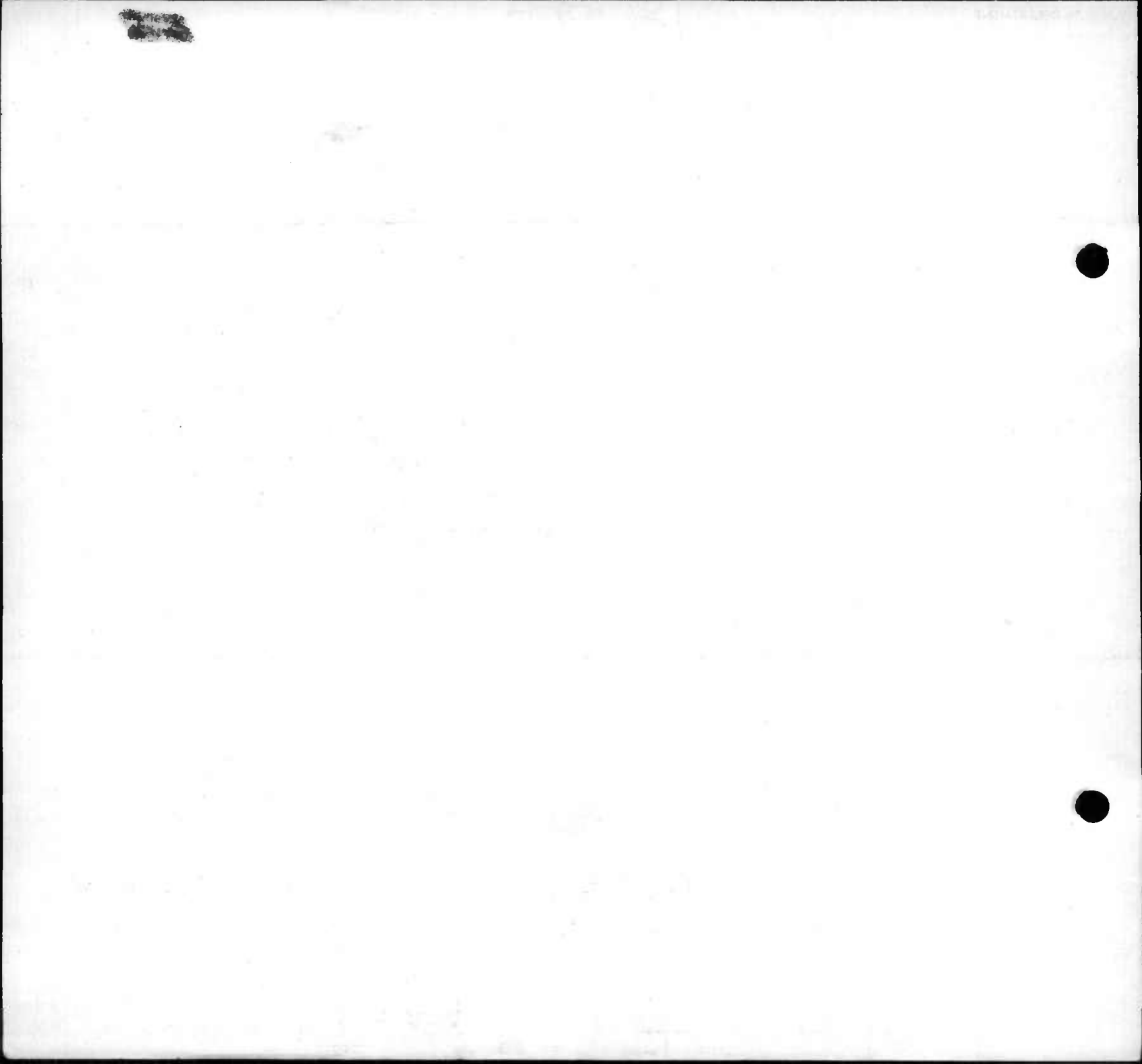
BALTIMORE CITY HEALTH DEPARTMENT				FOT: APPROVAL OF ME- LOCAL EXAMINER	
BIRTH NO. 69 12266				REG. NO. 69 12266	
1. NAME OF DECEASED (Type or Print) LESTER LESTER MOXLEY			2. DATE AND HOUR OF DEATH 12 8 69 11 A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2005 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2688 WILKENS AVENUE		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/86	9. AGE (In years last birthday) 83	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER - LABORER		10B. KIND OF BUSINESS OR INDUSTRY VARIOUS	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JESSE W MOXLEY			14. MOTHER'S MAIDEN NAME WILLIE ANNA (Brandenburg)		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-01 5436	17. INFORMANT BALTIMORE, MD 21229 ST AGNES HOSP RECORDS WILKENS & CATON		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			CAUSE OF DEATH PULMONARY EMBOLUS IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: EX HIP DUE TO, OR AS A CONSEQUENCE OF: none APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED ~16 days		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (APPROX) 11-22-69			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 2688 Wilkens Ave 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? fell out of bed		
22. I certify that (I) (this hospital) attended the deceased from 11-22-69 to 12-8-69 that (I) (we) last saw the deceased alive on 12-8-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward R. Cohen MD			23B. DATE SIGNED 12-8-69		23C. PHYSICIAN'S NAME (Type) EDWARD R. COHEN MD
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 12-10-69		24C. NAME OF CEMETERY OR CREMATORY Montgomery Chapel
25A. DATE REC'D BY HEALTH DEPT DEC 12 1969			25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR C.M. WATZ, Box 241, Sykesville, Md.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

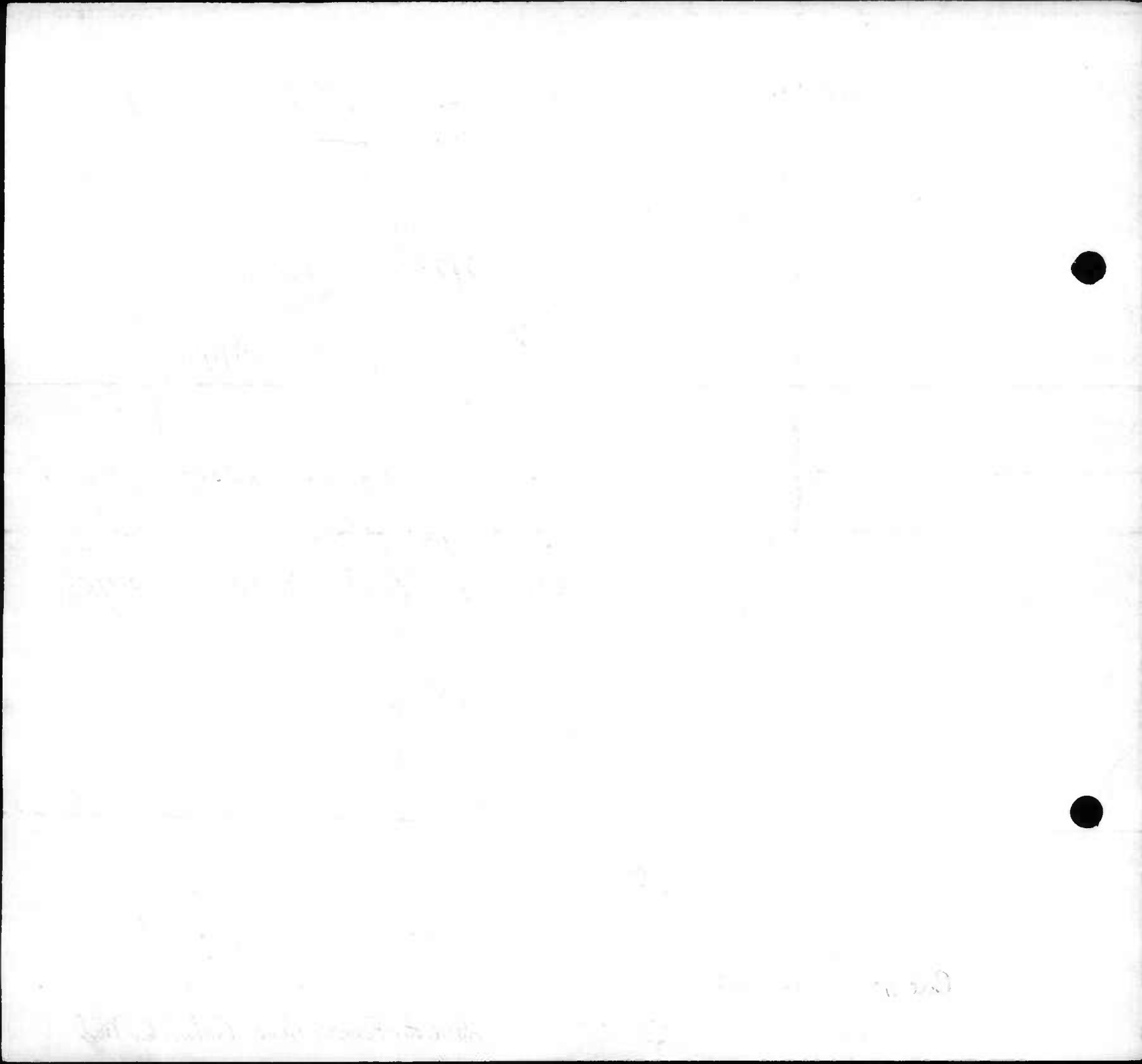
5-134		69 12267		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12267	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>John Sevdilis</i>			
2. DATE AND HOUR OF DEATH <i>12-9-69 6:30 PM</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Ba</i> B. COUNTY <i>ti</i>				5. FULL NAME OF HOSPITAL (OR INSTITUTION) (If not in hospital or institution, give street address or location) <i>Harbor View H.C.C. City 30</i>			
6. CITY OR TOWN <i>Ba</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				7. STREET AND NUMBER <i>1213 Light St.</i>			
8. SEX <i>m</i> 9. RACE <i>wh.</i>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. DATE OF BIRTH <i>3/25/94</i>		12. AGE (In years last birthday) <i>75yrs.</i>	
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14. KIND OF BUSINESS OR INDUSTRY			
15. BIRTHPLACE (State or foreign country) <i>Greece</i>				16. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
17. FATHER'S NAME				18. MOTHER'S MAIDEN NAME			
19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				20. SOCIAL SECURITY NO. <i>216-20-62554</i>			
21. INFORMANT				22. ADDRESS			
23. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Probable occult malignancy either gastro-intestinal or bronchogenic.</i>			
25. MEDICAL CERTIFICATION 19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>11/17</i> 19 <i>69</i> to <i>12/9</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>12/9</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Diadema Simon-Tayag</i> 23B. DATE SIGNED <i>12/10/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>DIADEMA SIMON-TAYAG</i>		23D. ADDRESS <i>8216 Thornton Rd, Towson, Md.</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-11-69</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>Greek Orthodox Cemetery</i>		24D. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1969</i>		25B. NAME OF REGISTRAR <i>Ruben E. Taylor</i>	
25C. FUNERAL DIRECTOR <i>Richard V. Matthews</i>		25D. ADDRESS <i>3027 Eastern Ave., Baltimore, Md.</i>		25E. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1969</i>		25F. NAME OF REGISTRAR <i>Ruben E. Taylor</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

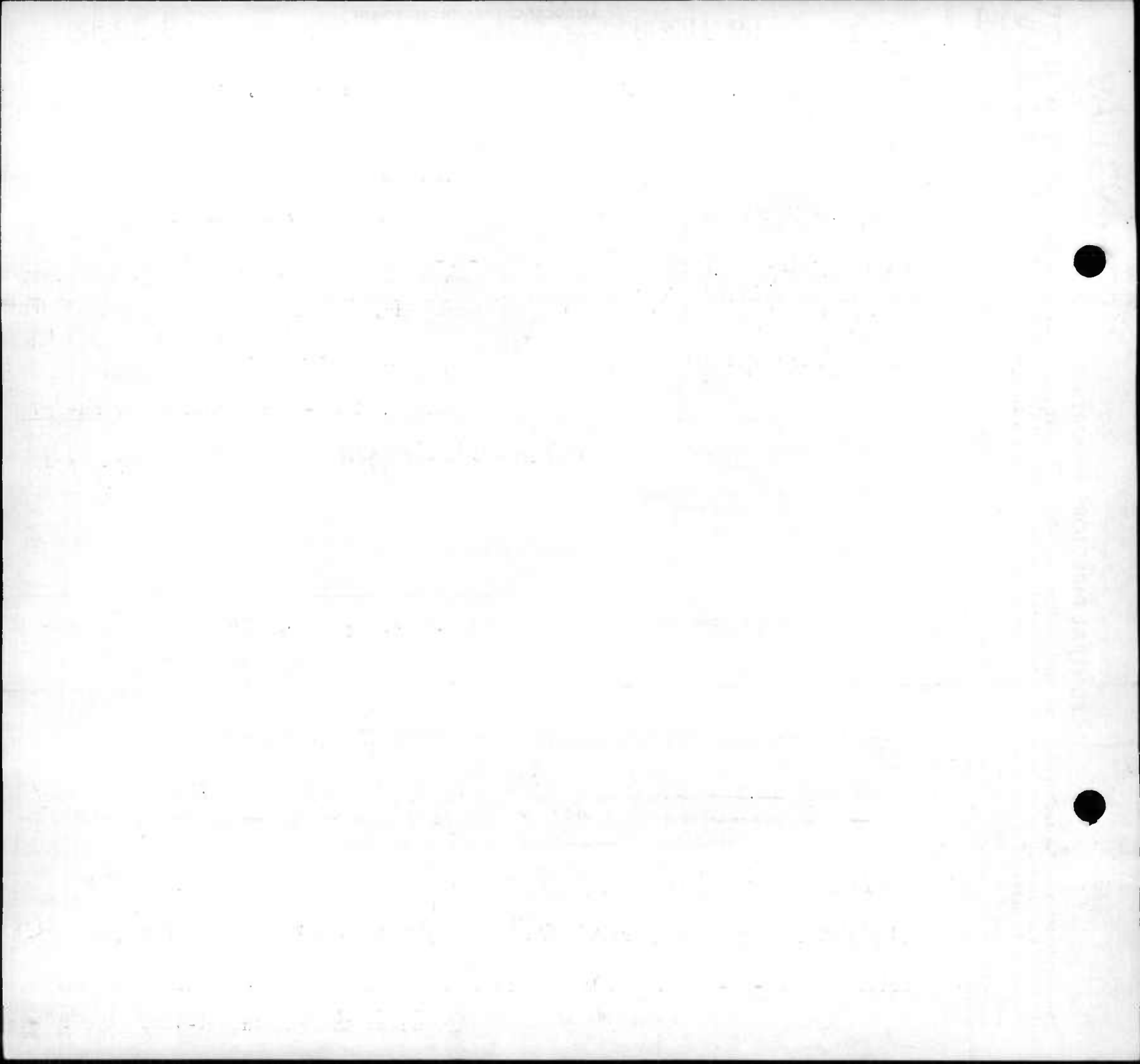
C-450 69 12268		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12268	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Adelaide Forbes Colhoun</u>		2. DATE AND HOUR OF DEATH <u>11/30/69</u> <u>1:55 A</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>BAFTA A.A.</u>		5200	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIV. Md. Hosp</u> <u>38 BALT. Md.</u>		C. CITY OR TOWN <u>HALLWOOD</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <u>CUMBERSTONE Rd.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/23/97</u>	9. AGE (In years last birthday) <u>72</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>USA</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>CHARLES N. COLHOUN</u>		14. MOTHER'S MAIDEN NAME <u>CORNELIA MURRAY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>JOHN COLHOUN</u>	
				ADDRESS <u>Md</u>	
18. <u>174X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA BREAST</u> <u>C METASTASES</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>CHF & pleural Effusion</u> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>17 yrs</u> <u>5 yrs</u> <u>2 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>11/24/69</u> 19 <u>64</u> to <u>11/30</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>11/28</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Howard Wallach, MD</u>		23B. DATE SIGNED <u>11/30/69</u>		23C. PHYSICIAN'S NAME (Type) <u>HOWARD WALLACH</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>12-3-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Crematory</u>	
24D. LOCATION <u>4000 Suitland Rd., Suitland, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1969</u>		25B. NAME OF REGISTRAR <u>John E. Fisher, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Handley Funeral Home, Galoville, Md</u>		25D. ADDRESS			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. 69 12269
BIRTH NO. 4-512 69 12269		1. NAME OF DECEASED (Type or Print) Helen A. Hamsch		
2. DATE AND HOUR OF DEATH December 8, 1969		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 90 ANDERSON NURSING HOME		
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 2802 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4416 Kathland Avenue 21207		5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 2-25-1889 9. AGE (In years (last birthday)) 80 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Annapolis, Maryland 12. CITIZEN OF WHAT COUNTRY? USA 13. FATHER'S NAME John Edward Feldmeyer 14. MOTHER'S MAIDEN NAME Sara Jane Brown 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. NO 17. INFORMANT Phyllis H. Field - 4416 Kathland Avenue #7 ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 41231 Arteriosclerotic Heart Disease 10 years ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II Aneurysm of thoracic aorta 5 years		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years 5 years		
19A. DATE OF OPERATION 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 22. I certify that (I) (this hospital) attended the deceased from July 19 61 to Dec 9, 1969, that (I) (we) last saw the deceased alive on Dec 4, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE Marvin Goldstein, M.D. 23C. PHYSICIAN'S NAME (Type) MARVIN GOLDSTEIN, M.D. 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-11-69 24C. NAME OF CEMETERY or CREMATORY St Anne's & Locust Grove Cemetery 24D. LOCATION (City, town, or county) (State) Annapolis Maryland 25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969 25B. NAME OF REGISTRAR 0000 25C. FUNERAL DIRECTOR Armacost ADDRESS Funeral Chapel-4600 Liberty Hts		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 23B. DATE SIGNED 12/11/69		



69 12270

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12270

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Clarence E. Johnson

2. DATE OF DEATH Known ☐ Month Day Year Hour
Estimated ☐ M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

(DOA) South Baltimore General Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
12 7 1969 10:12 P.M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE B. COUNTY
Md. 2653

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Sept. 30, 1910 59

10. AGE (In years last birthday)

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

5028 Orville St.

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

John Johnson

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Guard

14B. KIND OF BUSINESS OR INDUSTRY

Burns' Detective Agency

15. MOTHER'S MAIDEN NAME

Minnie D. Davis

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

249 18 7195

18. INFORMANT

ADDRESS

John C. Johnson 1616 Shadyside Rd. Balto., Md.

19. 412.417250.9
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

CAUSE OF DEATH

Arteriosclerotic cardiovascular disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

Diabetes mellitus

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12-8-69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/11/69

24C. NAME of CEMETERY or CREMATORY

Gardens of Faith Cemetery

24D. LOCATION (City, town, or county) (State)

Baltimore Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 12 1969

25B. NAME OF REGISTRAR

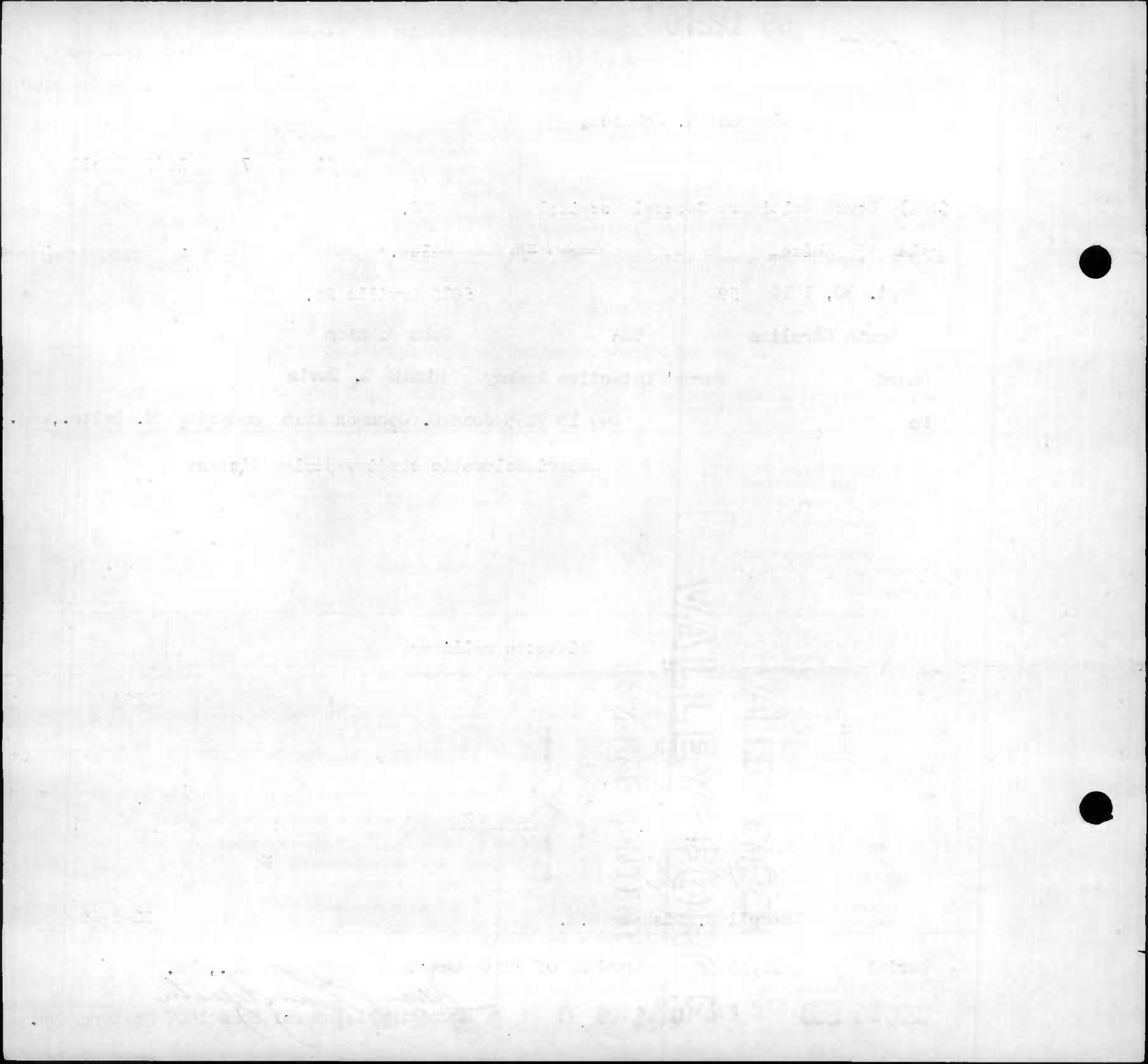
Russell S. Fisher, M.D.

25C. FUNERAL DIRECTOR

Bruzdzinski, Funeral Home

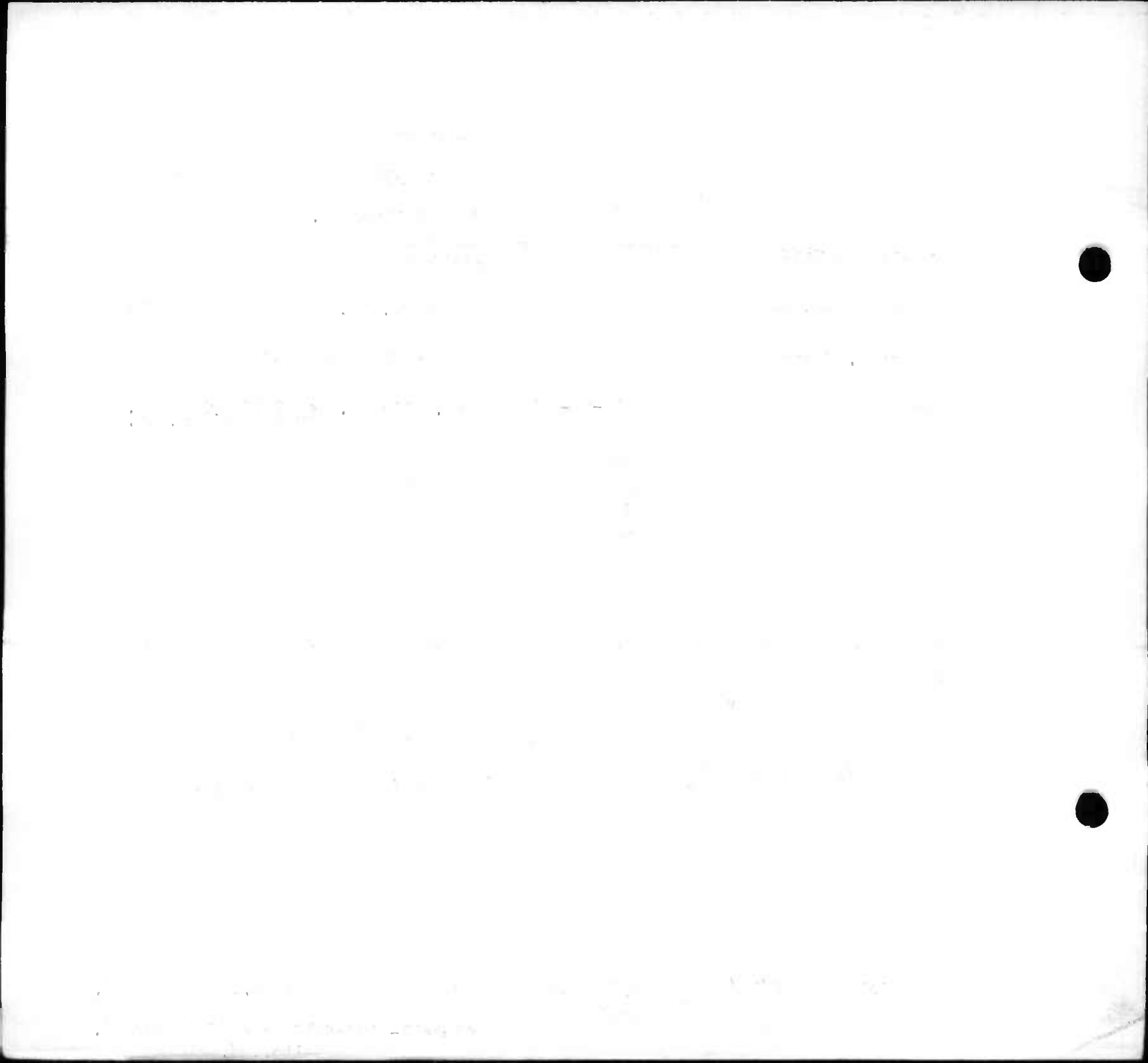
ADDRESS

1407 Eastern Ave.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

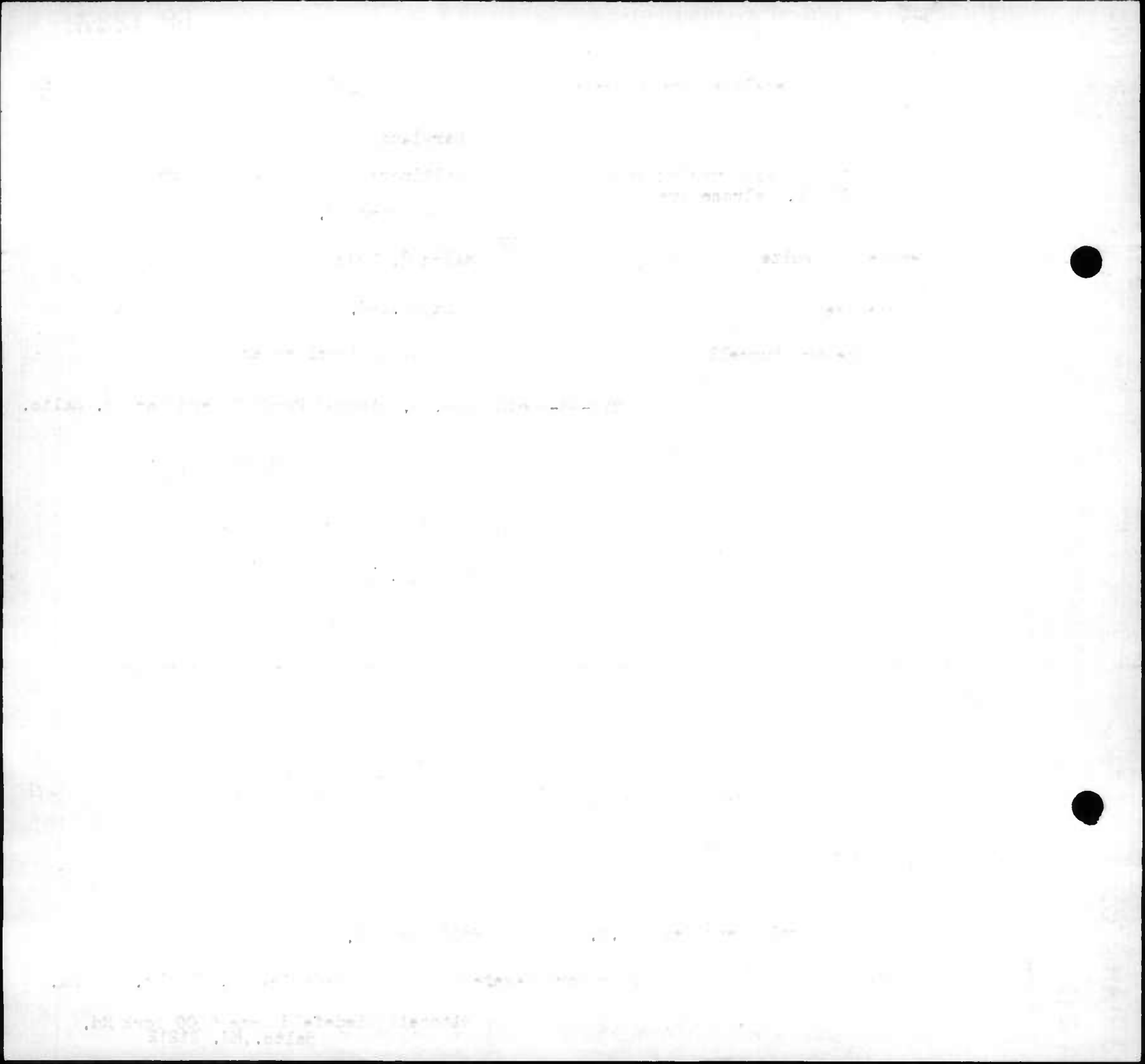
C-652 69 12271		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12271	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>JEANNETTE CORNS</i>		2. DATE AND HOUR OF DEATH <i>12-7-69 9³⁷/A. M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>906</i>		5. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>37 Mercy Hospital</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1829 Chilton St.</i>		6. SEX <i>female</i>		7. RACE <i>white</i>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		9. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		10. DATE OF BIRTH <i>4/26/1885</i>	
11. AGE (In years last birthday) <i>84</i>		12. If Under 1 Yr. Months: Days: Hours: Min.		13. If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>school teacher</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balto., Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Job D. Corns</i>		14. MOTHER'S MAIDEN NAME <i>Jeannette Madison</i>	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-46-0378T</i>		17. INFORMANT <i>Mrs. Alice C. Key 2315 Price Ave. Charlottesville, Va.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease or injury or complication which caused death.) <i>E887X</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) existing UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <i>Cardiopulmonary Arrest</i> DUE TO, OR AS A CONSEQUENCE OF:			
		(B) <i>Dehydration Dehydration</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>3 weeks</i>	
		(C) <i>Post op Reduction D hip</i> DUE TO, OR AS A CONSEQUENCE OF:		<i>4 weeks</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Relapse (84) post-operative infection</i>					
19A. DATE OF OPERATION <i>11/15/69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>FX R hip</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>living home</i>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>6116 Belair Rd 2134</i>		21D. TIME OF INJURY (APPROX.) <i>11-10-69 9AM</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <i>Fell to floor</i>		22. I certify that (I) (this hospital) attended the deceased from <i>11/10/69</i> 19 to <i>12/7</i> 1969 that (I) (we) last saw the deceased alive on <i>12/3/69</i> 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>A. KARAS</i>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <i>A. KARAS</i>	
23D. ADDRESS <i>MERCY HOSPITAL</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>12/10/69</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Loudon Park Cemetery</i>		24D. LOCATION (City, town, or county) <i>Balto., Md.</i>		24E. STATE <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Talbot</i>		25C. FUNERAL DIRECTOR <i>Mitchell-Wiedefeld Home</i>	
25D. ADDRESS <i>6500 York Rd. Balto., Md. 21212</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12272	
P-624 69 12272 BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Penelope Lynn Purcell			2. DATE AND HOUR OF DEATH 12/9/1969 5:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL, OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Long Green Nursing Home 115 E. Melrose Ave			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1201 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 7 Wendover Rd.		
5. SEX female	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 6, 1903	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker			10B. KIND OF BUSINESS OR INDUSTRY Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Steuart Purcell			14. MOTHER'S MAIDEN NAME Julia Eichelberger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-48-4961M		17. INFORMANT ADDRESS Mrs. G. Richard Purdy 7 Wendover Rd. Balto.	
18. CAUSE OF DEATH					
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBROVASCULAR ACCIDENT (B) DUE TO, OR AS A CONSEQUENCE OF: GENERALIZED ARTERIOSCLEROSIS (C) PARKINSON'S DISEASE </div> </div>					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from April 15 19 69 to Dec. 9 19 69 that (I) (we) last saw the deceased alive on Dec. 6 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 					
23A. SIGNATURE Marcio Menendez, M.D.				23B. DATE SIGNED 12-9-69	
23C. PHYSICIAN'S NAME (Type) Marcio Menendez M.D.				23D. ADDRESS 5820 York Rd.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/11/1969		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. J. [unclear]		25C. FUNERAL DIRECTOR ADDRESS Mitchell Wiedefeld Home 6500 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-250 69 12273				BALTIMORE CITY HEALTH DEPARTMENT		69 12273	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Charles Owen McKeown				December 7, 1969 3 ³⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 5511 Woodlawn Road.				A. STATE Maryland.			
(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
00				E. STREET AND NUMBER 5511 Woodlawn Road			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 29, 1897	9. AGE (In years last birthday) 72	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Utility man		10B. KIND OF BUSINESS OR INDUSTRY Proctor & Gamble		11. BIRTHPLACE (State or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Peter McKeown				14. MOTHER'S MAIDEN NAME XXXXXXXXXX Rose McMullen			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-03-6064		17. INFORMANT Margaret Mary McKeown		ADDRESS 5511 Woodlawn Rd.	
18. 163-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Cancer - prostatic 9 months (B) Emphysema - chronic lung disease years (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/61 1969 to 12/7 1969, that (I) (we) last saw the deceased alive on 12/7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert W. Swan, MD						23B. DATE SIGNED 12/7/69	
23C. PHYSICIAN'S NAME (Type) Dr. Robert W. Swan						23D. ADDRESS 7501 York Road	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/10/69		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. Balto., Md. 21212	

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FUNERAL DIRECTOR: IMPORTANT

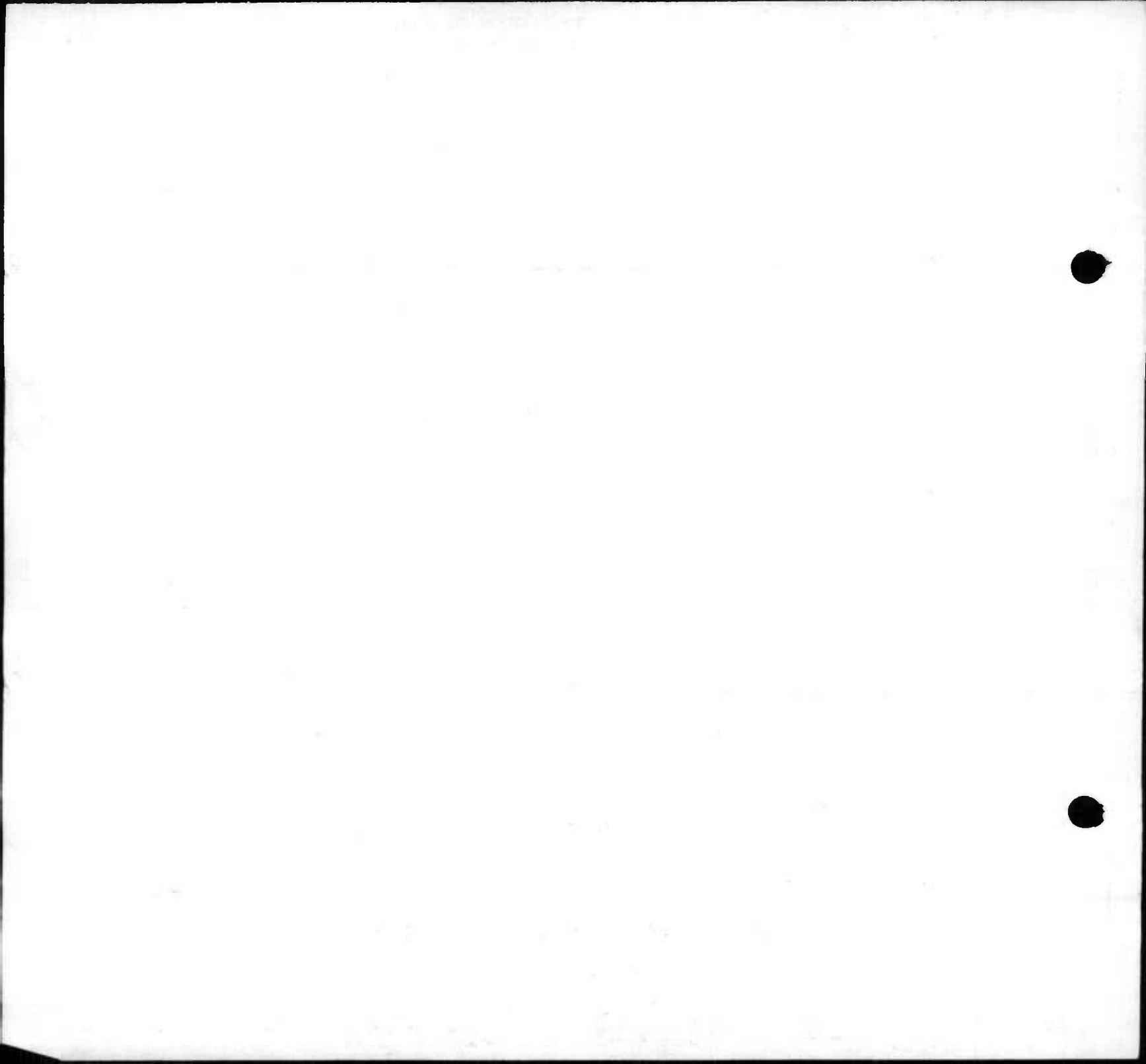
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12274	
<div style="display: flex; justify-content: space-between;"> C-620 69 12274 CERTIFICATE OF DEATH </div>					
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) CROSS, MILDRED J.		2. DATE AND HOUR OF DEATH 12/5/69 8.50 a. m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 2778			
FULL NAME OF HOSPITAL OR INSTITUTION GOOD SAMARITAN HOSPITAL 45		C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 6007 READY AVE.			
5. SEX F	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/96	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore Maryland	
13. FATHER'S NAME Edward Graham Jones		14. MOTHER'S MAIDEN NAME Mary Jane Kane			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-32-9826		17. INFORMANT B-Mr. P. Irving Cross-6007 Ready Ave. 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/12/41-250.9		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Brain Stem CVA.		17 days	
		(B) Anteriosclerotic Cardiovascular disease		5 years	
		(C) Diabetes mellitus		8 years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/4/1969 to 11/18/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE D.H. Sherbourne				23B. DATE SIGNED 12/5/69	
23C. PHYSICIAN'S NAME (Type) D.H. SHERBOURNE				23D. ADDRESS 6007 SAMARITAN HOSPITAL 6001 LAM RAVEN BLVD BALTO 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/8/69		24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Mem. Gardens	
24D. LOCATION (City, town, or county) Balto. Co.		25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969			
25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR 6500 York Rd. 21212 J.S.G.			

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

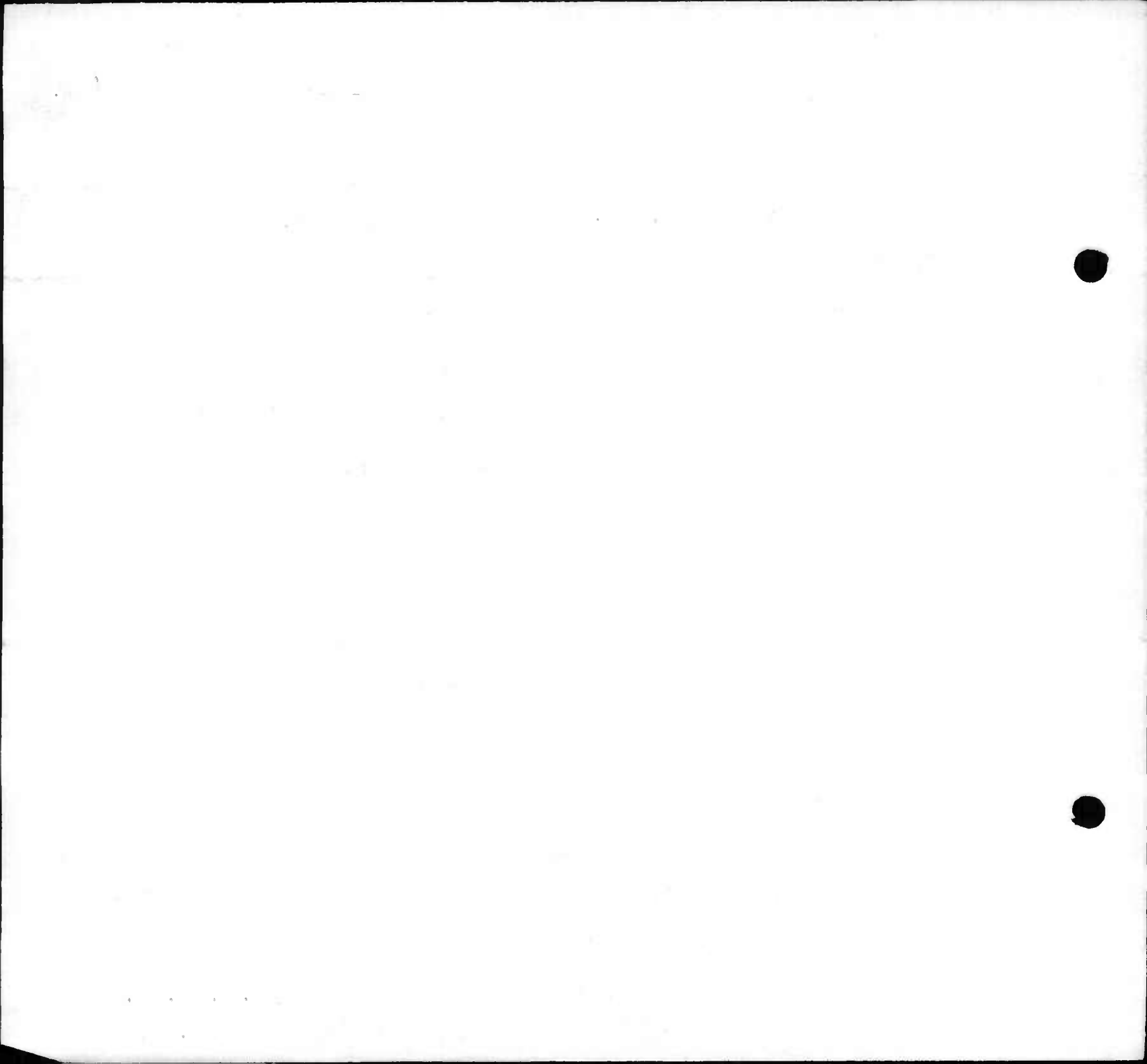
<div style="display: flex; justify-content: space-between;"> S-400 69 12275 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12275	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) SALA FRANK		2. DATE AND HOUR OF DEATH 12-9-69 1:15 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Baltimore General Hospt 3001 S Hanover Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 138 S. Charles St. 401			
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 138 S Charles Street					
5. SEX male	6. RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-23-93	9. AGE (In years last birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME CARL		14. MOTHER'S MAIDEN NAME MICHAELIN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-4872		17. INFORMANT Family Same ADDRESS _____	
18. 410.9 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Myocardial infarction (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: M.I. (B) DUE TO, OR AS A CONSEQUENCE OF: MI (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (H) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (H) (we) lost saw the deceased alive on 12-9-69 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE N.Y. Yaman		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12-9-69	
23C. PHYSICIAN'S NAME (Type) NABIL YACUB Yaman		23D. ADDRESS South Baltimore General Hospt			
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 12/13/69		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) Baltimore		24E. STATE Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR A. G. Kelly ADDRESS 130 E. Fort Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> M-500 69 12276 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12276	
BIRTH NO. _____ 1. NAME OF DECEASED (Type or Print) DONNA MAHONEY		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> 12-11-69 3:00 A. </div>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 MERCY HOSPITAL, INC.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY 2303 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1705 OLIVE ST.			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-28-39	9. AGE (In years last birthday) 30	11. Under 1 Yr. Months: _____ Days: _____ 12. Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME ALLEN COLE		14. MOTHER'S MAIDEN NAME ELONA VON COYN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. _____		17. INFORMANT Emerald Cole	
				ADDRESS 282 Hillside Terrace	
18. 5-6-7-8-9-10-11-12-13-14-15-16-17-18-19-20-21-22-23-24-25-26-27-28-29-30-31-32-33-34-35-36-37-38-39-40-41-42-43-44-45-46-47-48-49-50-51-52-53-54-55-56-57-58-59-60-61-62-63-64-65-66-67-68-69-70-71-72-73-74-75-76-77-78-79-80-81-82-83-84-85-86-87-88-89-90-91-92-93-94-95-96-97-98-99-100 CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE Acute PERITONITIS DUE TO, OR AS A CONSEQUENCE OF: _____ (B) DUE TO, OR AS A CONSEQUENCE OF: _____ (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) YES	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (if this hospital) attended the deceased from 11-28-69 to 12-11-69 that (I) (we) last saw the deceased alive on 12-11-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Bayani L. Manalo, M.D.				23B. DATE SIGNED 12-11-69	
23C. PHYSICIAN'S NAME (Type) BAYANI L. MANALO, M.D.		23D. ADDRESS _____			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12 15 69		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Brooklyn, A. A. Co. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969			
25B. NAME OF REGISTRAR John E. Kelly		25C. FUNERAL DIRECTOR ADDRESS 130 E. Fort-Ave			



P-362

69 12277

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12277

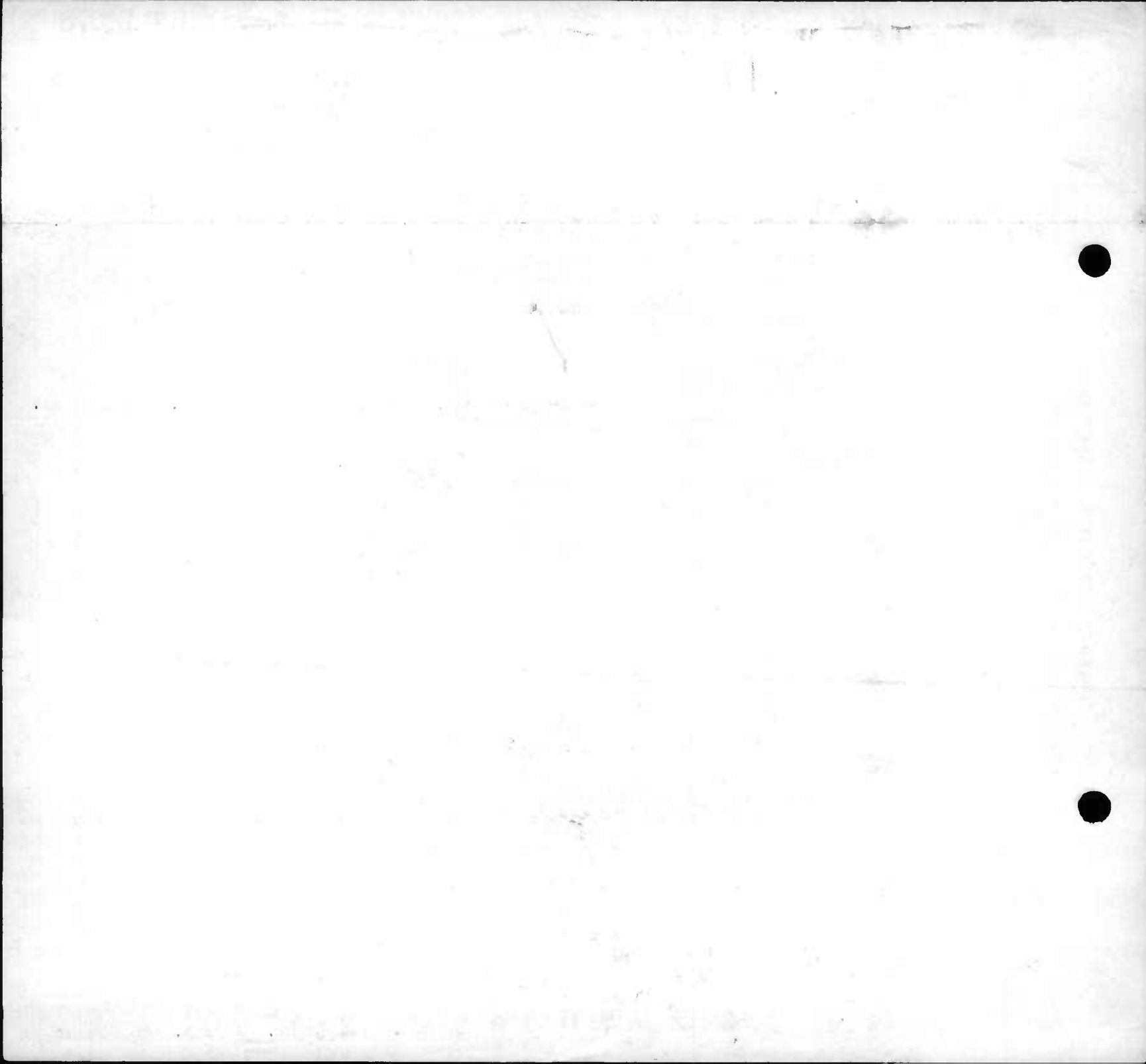
BIRTH NO.

1. NAME OF DECEASED (Type or Print) Charles H. Peterson				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 34 Bon Secours Hospital (If not in hospital or institution, give street address or location)				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 7 1969 11:57 AM			
6. SEX Male				7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH MAY 12, 1943				10. AGE (In years last birthday) 26		11. BIRTHPLACE (State or foreign country) Balto. Md.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME Harold Hunter		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter	
15. MOTHER'S MAIDEN NAME Mary Peterson				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Sam Peterson				ADDRESS 1619 W. Lexington St.			
19. E 887 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Subdural Hematoma DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1619 W. Lexington St.				22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12 7 69 5 A			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? Subject fell through door			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-8-69							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/11/1969		St. Luke's Church		Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Williams Funeral Home		ADDRESS 319 N. Schenck St.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12278	
P-120 69 12278		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>George L. Phipps</i>		2. DATE AND HOUR OF DEATH <i>12/9/69</i> 67 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2610</i>		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>116 S. Bouldin Street</i>		E. STREET AND NUMBER <i>116 S. Bouldin Street</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/21/'04</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Western Electric</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George Phipps</i>		14. MOTHER'S MAIDEN NAME <i>Janie ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-01-5344A</i>		17. INFORMANT <i>Mrs. Anna Mae Phipps</i>	
18. <i>162.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive Cardiac Failure</i> (B) <i>Carcinomatous</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Lung Carcinoma</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>12/30/69</i> 19 to <i>12/9/69</i> 19, that (I) (we) last saw the deceased alive on <i>12/9/69</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Andrew Kurkowski, M.D.</i>				23B. DATE SIGNED <i>12/11/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Andrew Kurkowski M.D.</i>				23D. ADDRESS <i>2529 Eastern Ave. Baltimore Md 21224</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/12/69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>		25C. FUNERAL DIRECTOR <i>John A. Moran, Inc.</i>	
ADDRESS <i>3000 E. Baltimore St.</i>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-250 69 12279				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12279	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BACON, NETTIE				2. DATE AND HOUR OF DEATH 12-9-69 7-0 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY 1608			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Lutheran Hospital of MD. 46				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 619 Linnaard St.			
5. SEX F	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-19-99	9. AGE (In years last birthday) 70 yr	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME A. Striffin				14. MOTHER'S MAIDEN NAME Maggie Darsey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-4703		17. INFORMANT Maggie Huffman		ADDRESS 619 Linnaard St.	
18. 2-5-0-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Diabetes with C.V.A.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: C.V.A. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2-5-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? -	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) -		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -			
22. I certify that (I) (this hospital) attended the deceased from 11-9-69 to 12-9-69 , that (I) (we) last saw the deceased alive on 12-9-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Kantilal J. Shah MD				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-9-69	
23C. PHYSICIAN'S NAME (Type) KANTILAL J. SHAH MD				23D. ADDRESS Lutheran Hospital			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-14-69		24C. NAME OF CEMETERY OR CREMATORY Elizabeth		24D. LOCATION (City, town, or county) (State) Elizabeth City, N. C.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. Taylor MD		25C. FUNERAL DIRECTOR Charles G. Rice		ADDRESS 661 W. Bane St.	

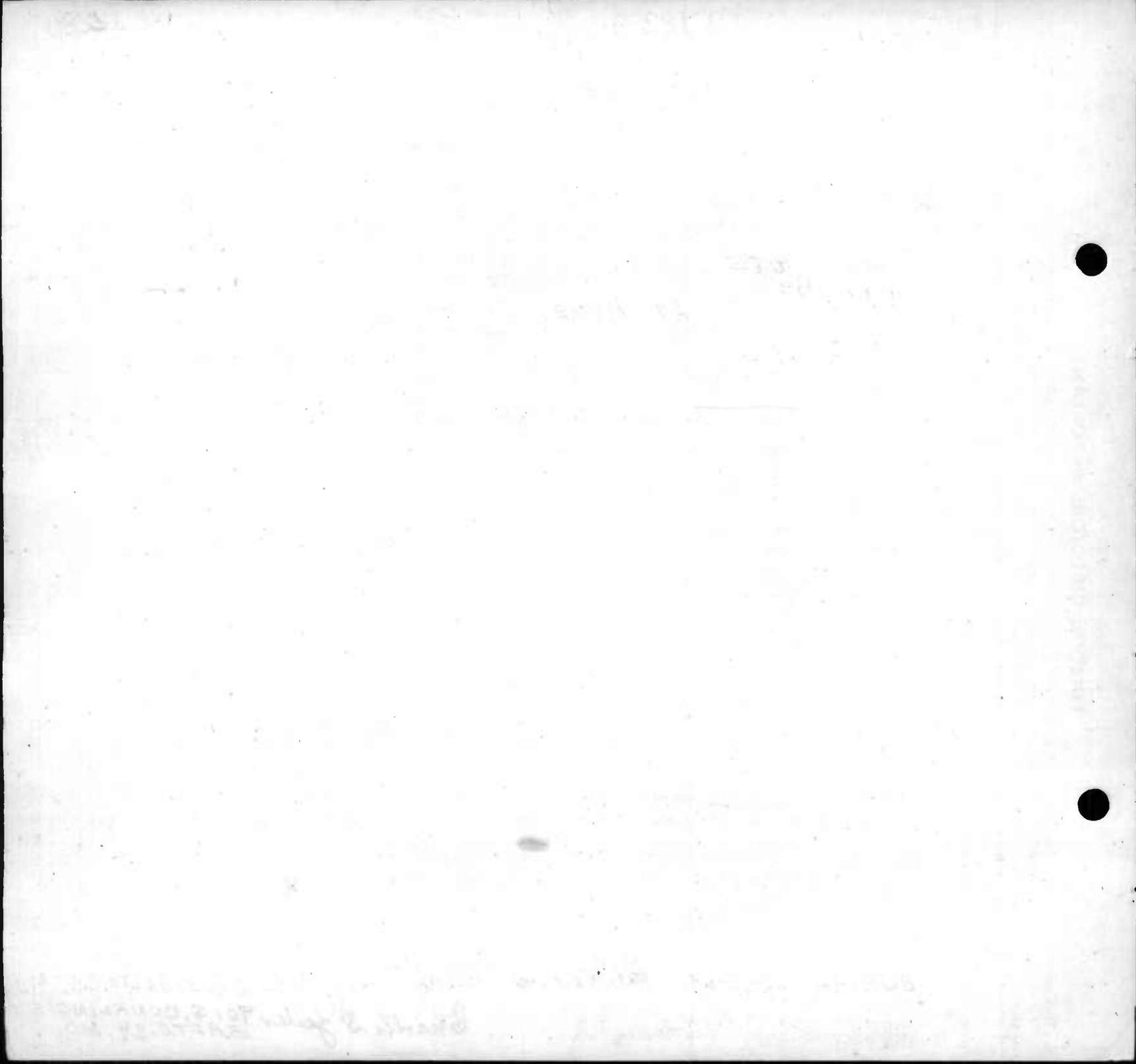
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A-V 9

KAY TILAL 2 MARIANO LUGARON HOSPITAL
KAY TILAL 2 MARIANO LUGARON HOSPITAL

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-145		69 12280		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12280	
CERTIFICATE OF DEATH							
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>DeBloom, Mary Gesine</u>				2. DATE AND HOUR OF DEATH <u>12-10-1969</u> <u>4:00 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>North Charles General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21206</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5403 Knell Avenue</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-18-92</u>	9. AGE (In years lost birthday) <u>77</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AT HOME.</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John G. Nehus</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth ROHDE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-34-9126</u>		17. INFORMANT <u>NCG.H. chart</u>		ADDRESS	
18. <u>25019</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>Cerebral vascular accident</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic cardiovascular disease</u> <u>Diabetes mellitus</u> <u>Dehydration</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Dehydration</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12-9</u> 19 <u>69</u> to <u>12-10</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12-10</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>V. Chitrapal</u> OEGREE						23B. DATE SIGNED <u>12-10-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>V. CHITRAPAL</u>				23D. ADDRESS <u>North Charles General Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-13-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>MORELAND MEMORIAL</u>		24D. LOCATION (City, town, or county) (State) <u>2901 TAYLOR AVE. BALTO. CO., MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1969</u>		25B. NAME OF REGISTRAR <u>Charles S. Zeiler</u>		25C. FUNERAL DIRECTOR <u>401 S. CONKLING ST. BALTO. 24, MD.</u>		ADDRESS	

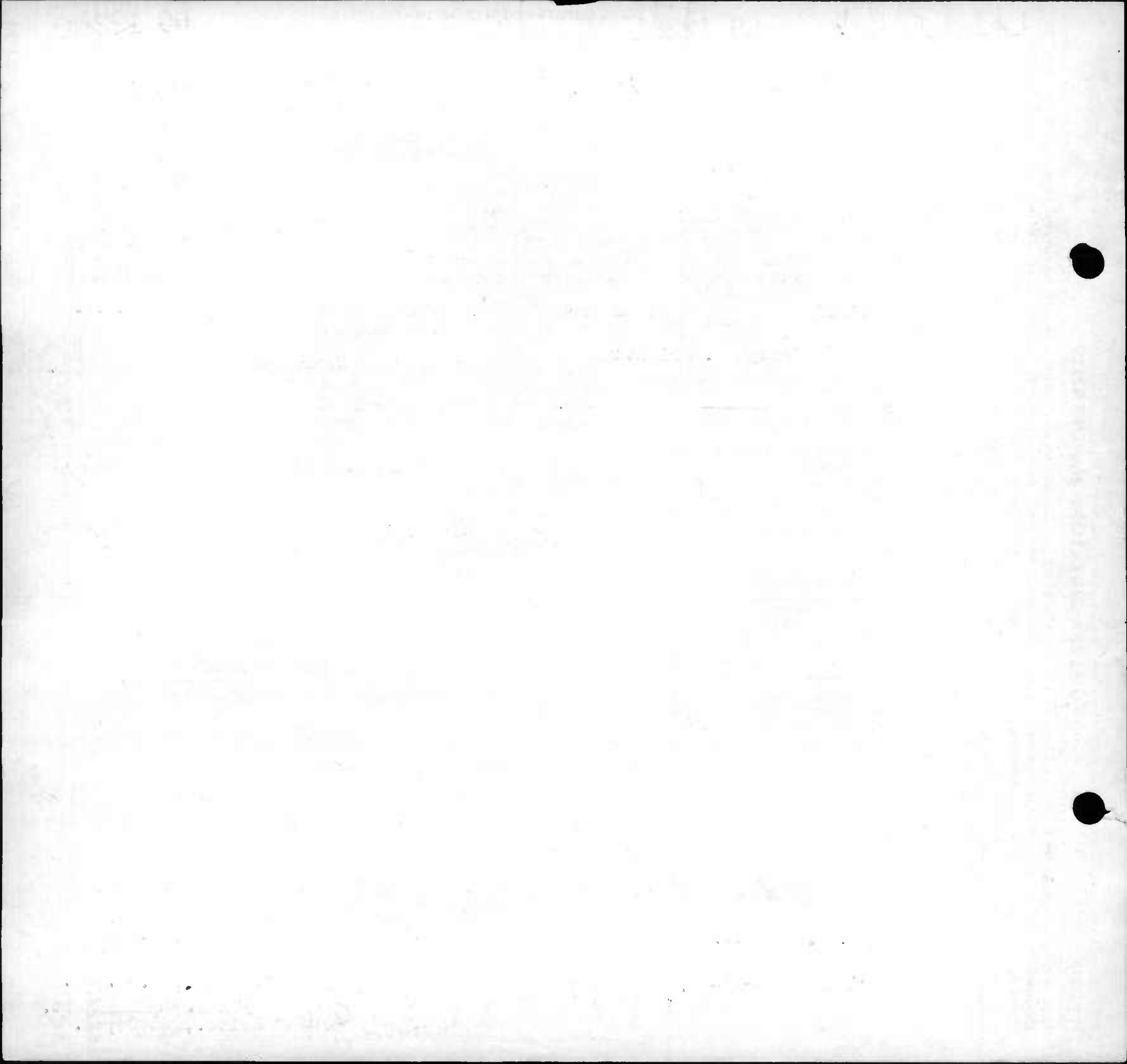


FUNERAL DIRECTOR: IMPORTANT

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55-90-1-63

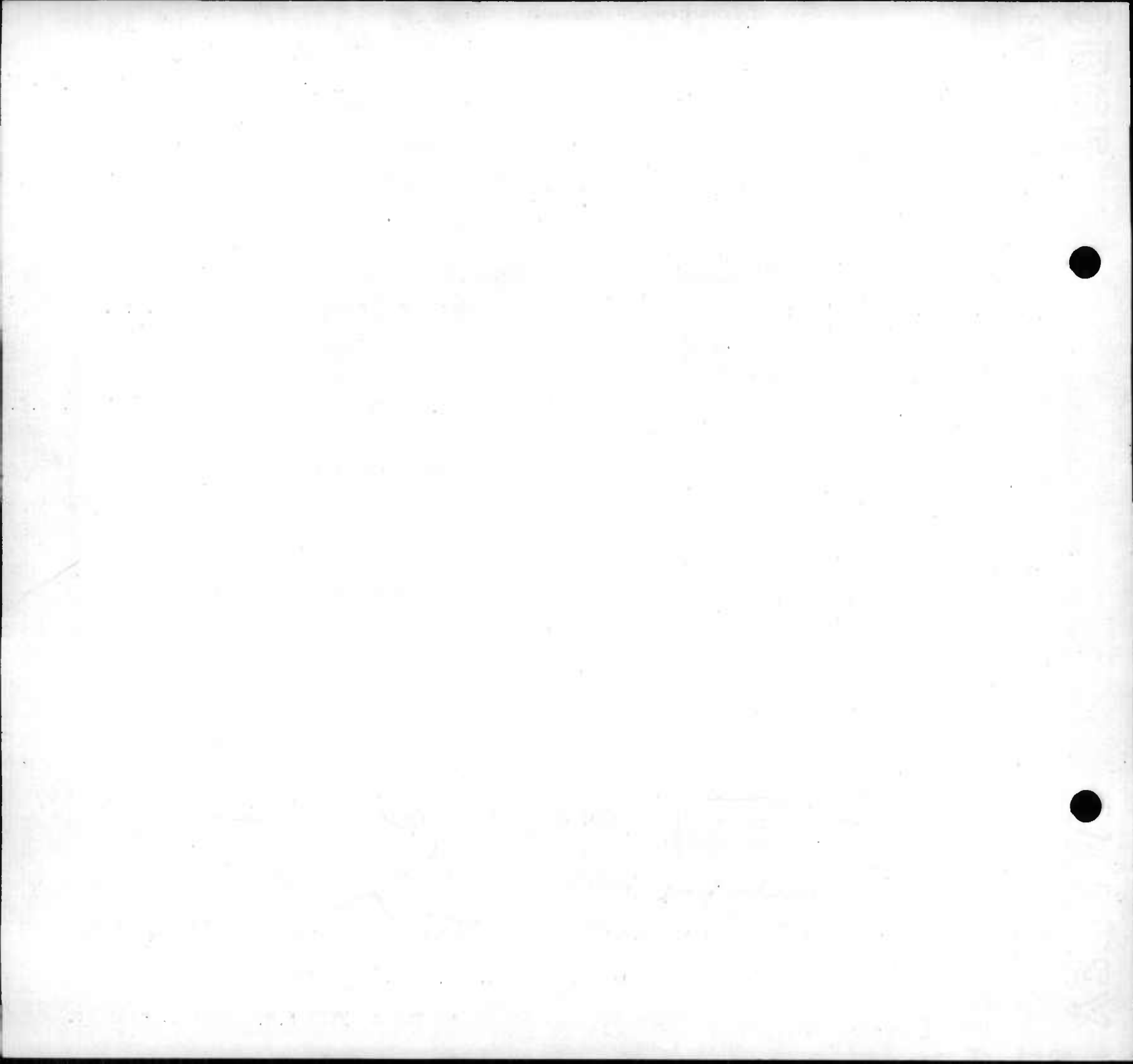
BALTIMORE CITY HEALTH DEPARTMENT				69 12281	
CERTIFICATE OF DEATH				REG. NO. 69 12281	
BIRTH NO. J-260					
1. NAME OF DECEASED (Type or Print) Sarah Ann Fisher			2. DATE AND HOUR OF DEATH 12:15 PM 12/10/69		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION BALTIMORE CITY HOSPITALS			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4940 Eastern Avenue			B. COUNTY 2609		
Baltimore, Maryland 21224			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 3803 Fait Avenue 21224		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-10-81	9. AGE (In years lost birthday) 88	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph F. Krichton			14. MOTHER'S MAIDEN NAME Anastasia Barranger		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 214-56-5380J		
			17. INFORMANT ADDRESS 4940 Eastern Avenue		
			BCH: Records Baltimore, Maryland 21224		
18. 43391			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Thrombosis		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			(B) Senile Dementia DUE TO, OR AS A CONSEQUENCE OF: 3 years		
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 12/2 19 69 to 12/10 19 69 , that (1) (we) last saw the deceased alive on 12/10 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Edward J. Lee M.D.				23B. DATE SIGNED 12/10/69	
23C. PHYSICIAN'S NAME (Type) Edward J. Lee M.D.				23D. ADDRESS BALTIMORE CITY HOSPITALS 21224 4940 Eastern Avenue Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-13-69.	24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) 3320 Taylor Ave., Ba. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Charles E. Fisher		25C. FUNERAL DIRECTOR Charles E. Fisher	
				ADDRESS 901 S. Conkling St. Balto., 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

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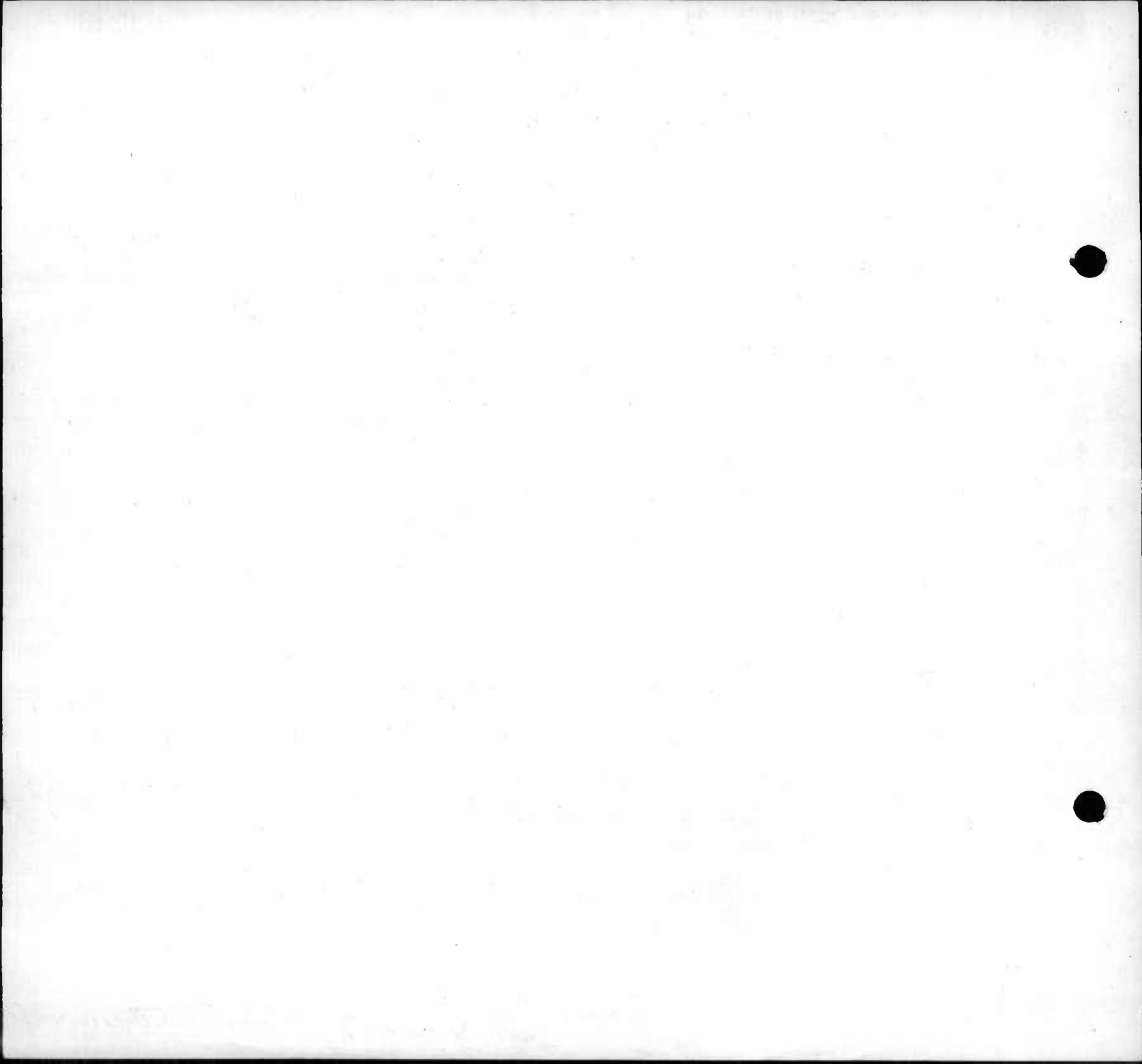
J-435 69 12282		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12282	
BIRTH NO.		1. NAME OF DECEASED (Luetta) Clara LORETTA FELTON		2. DATE AND HOUR OF DEATH 12-10-69 11.35 P			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NORTH CAROLINA B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL				C. CITY OR TOWN HERTFORD		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 322 W. MARKET STREET			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-7-09	9. AGE (In years last birthday) 60	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Work		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hertford, North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLIE HUDSON				14. MOTHER'S MAIDEN NAME CLARA HUDSON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Melissa Cox		ADDRESS 2425 Naylor Rd Wash., D.C.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARCINOMA - LUNG ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 10 19 69 to Dec 10 19 69, that (I) (we) lost saw the deceased alive on Dec 10, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Richard Bensinger MD				23B. DATE SIGNED 12/10/69		23C. PHYSICIAN'S NAME (Type) RICHARD BENNINGER MD	
23D. ADDRESS JOHNS HOPKINS HOSPITAL				23E. FURNAL DIRECTOR MORTON & DYETT F.H.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-14-69		24C. NAME of CEMETERY or CREMATORY New Bethel Bapt. Ch. Cem.		24D. LOCATION (City, town, or county) (State) Hertford, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. Kelly		25C. FURNAL DIRECTOR MORTON & DYETT F.H.		ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12283	
69 12283				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MURDOCK, SAMUEL E.		2. DATE AND HOUR OF DEATH 12-11-69 5⁰⁰ A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD LUTHERAN HOSPITAL OF, MD. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 46		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY 1605 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2544 ARUNAH AVE.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-83	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RET. LABORER		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL		11. BIRTHPLACE (State or foreign country) HOWARD CO MD	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SAMUEL MURDOCK		14. MOTHER'S MAIDEN NAME MARY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218225609B		17. INFORMANT M. BRED SMITH 2544 ARUNAH AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 600X 250.9 anemia		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic pyelonephritis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 day	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: B.P.H. Diabetes mellitus		(C) 2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Serum electrolyte disturbance					
19A. DATE OF OPERATION 12/1/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED BPH		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <input type="checkbox"/>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from 11/24/69 19 to 12/11/69 19, that (I) (we) last saw the deceased alive on 12/11/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Subash C. Ahuja				23B. DATE SIGNED 12/11/69	
23C. PHYSICIAN'S NAME (Type) SUBASH C. AHUJA				23D. ADDRESS Lutheran Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn	
24D. LOCATION (City, town, or county) (State) BALTO MD					
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Dr. E. Taylor		25C. FUNERAL DIRECTOR James P. Henry 675 69, 12th St	



OSL 2

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12284	
BIRTH NO. H-200		69 12284		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CLARENCE HICKS		2. DATE AND HOUR OF DEATH 12/9/69			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION The Johns Hopkins Hospital		A. STATE Maryland		B. COUNTY 802	
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 2108 E. Lafayette Avenue					
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/10/10	9. AGE (In years lost birthday) 59 57	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Rice, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Henry Hicks		14. MOTHER'S MAIDEN NAME Ida Hancock			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W. 2		16. SOCIAL SECURITY NO. 218-07-4017		17. INFORMANT John Hicks 2036 E. Lanvale St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 540.01 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Sepsis (B) DUE TO, OR AS A CONSEQUENCE OF: Peritonitis (C) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A): Acute Renal Failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 week	
19A. DATE OF OPERATION 11/23/69 + 12/3/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ruptured appendix, Perforated Vagus		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 23 1969 to Dec 9 1969, that (I) (we) last saw the deceased alive on Dec 9 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Hayden G. Braine M.D.				23B. DATE SIGNED 12/9/69	
23C. PHYSICIAN'S NAME (Type) Hayden G. Braine, M.D.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-69		24C. NAME OF CEMETERY or CREMATORY National Cemetery, Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969		25B. NAME OF REGISTRAR Robert E. F. B. No. 000		25C. FUNERAL DIRECTOR Rudolph J. Collick 2431 E. Oliver St.	

11-11-51

Dear Mr. Rice,

Very truly yours,

Walter D. Byrd

Dec 2 1951

WD

Walter D. Byrd

X

12/2/51

Walter D. Byrd

Walter D. Byrd

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 69 12285		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12285	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) BRAC, ARTURO J.		2. DATE AND HOUR OF DEATH 12/12/69. 6:50 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 105	
FULL NAME OF HOSPITAL OR INSTITUTION 43 South Baltimore Gen. Hospital Baltimore MD.		E. STREET AND NUMBER 2129 E BALTIMORE ST			
5. SEX M	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/27/1911	9. AGE (In years last birthday) 58	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHECKER		10B. KIND OF BUSINESS OR INDUSTRY BETH STEEL CO		11. BIRTHPLACE (State or foreign country) Puerto Rico	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arturo (Dec)		14. MOTHER'S MAIDEN NAME Julia Hernandez	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 061-24-8605		17. INFORMANT MARIA M. BRAC 2129 E BALTIMORE ST	
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bronchopneumonia Cardio-respiratory failure (B) Metastatic Ca of Unknown Origin DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/11/69 to 12/12/69 and that (I) (we) last saw the deceased alive on 12/12/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE S. M. Glover		23B. DATE SIGNED 12/12/69		23C. PHYSICIAN'S NAME (Type) S. M. Glover	
23D. ADDRESS S. Baltimore Gen. Hospital.		23E. DEGREE		23F. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC 15 1969		24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEMETERY	
24D. LOCATION (City, town, or county) (State) EASTERN AVE BLVD BALTO MD		24E. DATE REC'D BY HEALTH DEPT. DEC 12 1969		24F. NAME OF REGISTRAR Paul E. Taylor, M.D.	
24G. FUNERAL DIRECTOR THE DIRPPE BROS INC 1800 E LOMBARD ST		24H. ADDRESS		24I. ADDRESS	

South Atlantic
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Quinto & Co
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John H. ...

Metropolitan & ...
Carter & ...

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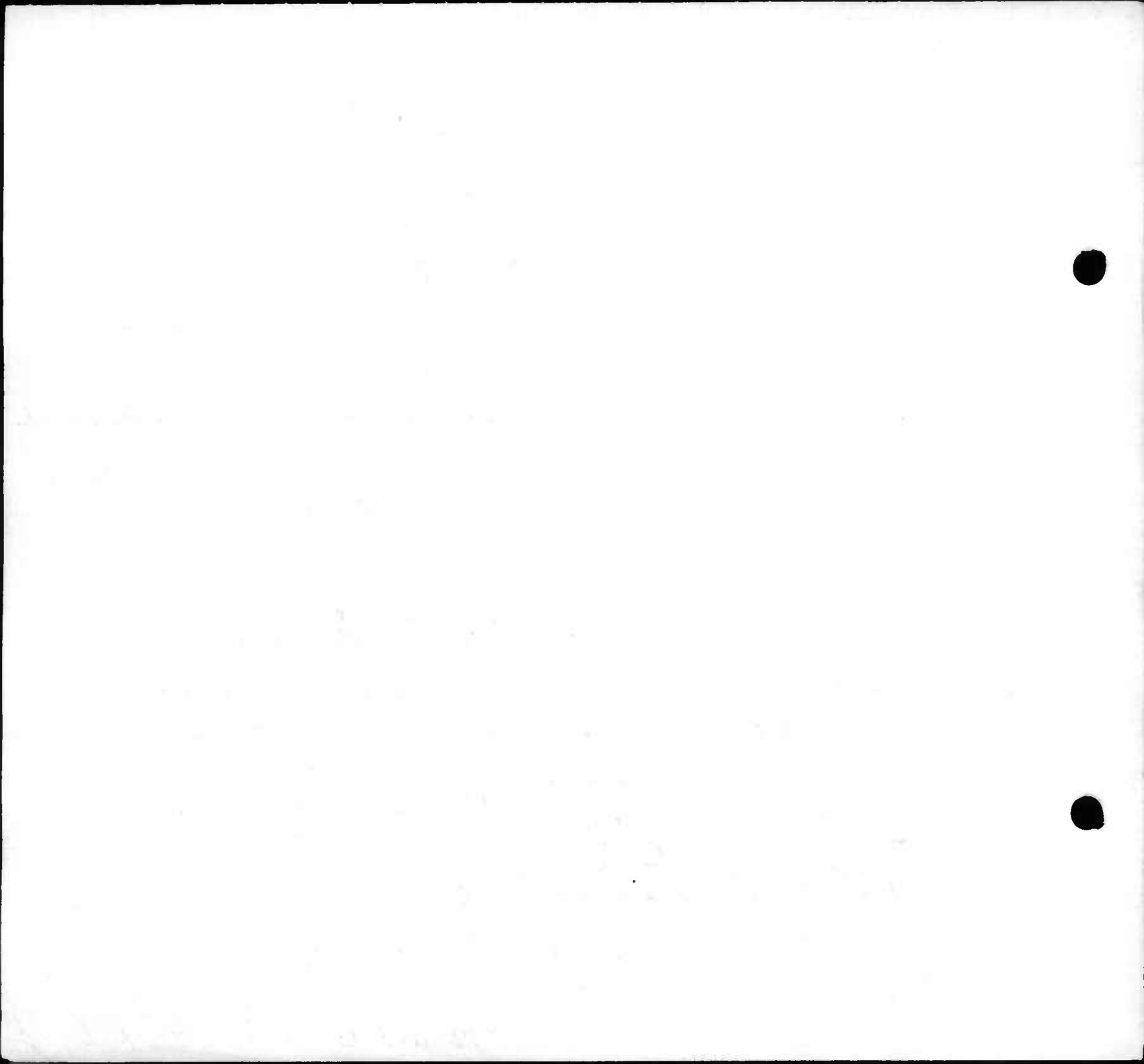
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-453		69 12286		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12286	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) ANNA K. Welinder				2. DATE AND HOUR OF DEATH 12-10-69 7⁵⁰ P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Mercy Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 8. COUNTY BALto.			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital				C. CITY OR TOWN BALto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1535 Windemere Ave.							
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-27-09	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) BALTIMORE	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Nicholas Sewicki				14. MOTHER'S MAIDEN NAME MARY Prochorowska			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. —		17. INFORMANT Ivar B. Welinder	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CEREBRAL VASCULAR ACCIDENT				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9hr.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYPERNEPHROMA - PNEUMONIA - ATYPICAL - PANCREATITIS							
19A. DATE OF OPERATION 3-15-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED HYPERNEPHROMA		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —			
22. I certify that (I) (his hospital) attended the deceased from 11-22 1969 to 12-10 1969 that (I) (we) last saw the deceased alive on 12-10 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Robert L. Doyle MD				23B. DATE SIGNED 12-10-69			
23C. PHYSICIAN'S NAME (Type) Robert L. Doyle MD				23D. ADDRESS Mercy Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-69		24C. NAME OF CEMETERY OR CREMATORY Holy Trinity Cem.		24D. LOCATION (City, town, or county) (State) Elkridge Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. Doyle		25C. FUNERAL DIRECTOR Pappert Bros Inc.			
				ADDRESS 7114 Belair Rd			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620		69 12287		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12287	
1. NAME OF DECEASED (Type or Print) <i>Lillian Brooks</i>				2. DATE AND HOUR OF DEATH <i>12-7-1969 11²⁰ AM.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>90 Bolton Hill Nursing Home</i>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1702</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1316 Eutan Place</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>6-18-65</i>	9. AGE (In years last birthday) <i>64</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Charles Brooks</i>				14. MOTHER'S MAIDEN NAME <i>ELLA Roberson</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>218-30-5899</i>		17. INFORMANT ADDRESS <i>John Westly Brooks Bel Air MD</i>			
18. <i>182.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>CAT uterus with cancerous</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Jan, 1969</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/14</i> 19 <i>69</i> to <i>12/7</i> 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>12/7</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Al Martin</i>				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12/8/69</i>	
23C. PHYSICIAN'S NAME (Type) <i>Arthur H. MACHT</i>				23D. ADDRESS <i>2 E Red St Bel Air MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Buried</i>		24B. DATE <i>12-11-69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Greenwood</i>		24D. LOCATION (City, town, or county) (State) <i>Churchville Bel Air MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 12 1969</i>		25B. NAME OF REGISTRAR <i>John E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>517 E Bel Geor & W</i>			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-552		69 12288		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12288	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) VIVIAN PENNINGTON				2. DATE AND HOUR OF DEATH 12/11/69 9:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2716		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION 4808 HOMER AVE 00 BALTIMORE, Md.		E. STREET AND NUMBER 4808 HOMER AVE - 15		5. SEX F		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1907		9. AGE (In years last birthday) 62		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elijah Barnes		14. MOTHER'S MAIDEN NAME Julia Barnes		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-314		17. INFORMANT (Son) John Pennington, Jr.	
18. 150 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH METASTATIC CARCINOMA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SQUAMOUS CELL CARCINOMA OF THE ESOPHAGUS. (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
19A. DATE OF OPERATION 8-1-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA OF ESOPHAGUS		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 7/27/69 19 to 11/25/69 19, that (1) (we) lost the deceased alive on 11/25/69 19 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (do) (did not) view the body after death.		23A. SIGNATURE Allan Land		23B. DATE SIGNED 12/11/69					
23C. PHYSICIAN'S NAME (Type) ALLAN LAND		23D. ADDRESS Senai Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-69		24C. NAME OF CEMETERY or CREMATORY Not known	
24D. LOCATION (City, town, or county) (State) Balt Md		25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Chas. W. Brown		25D. ADDRESS 1001 Brantly St	

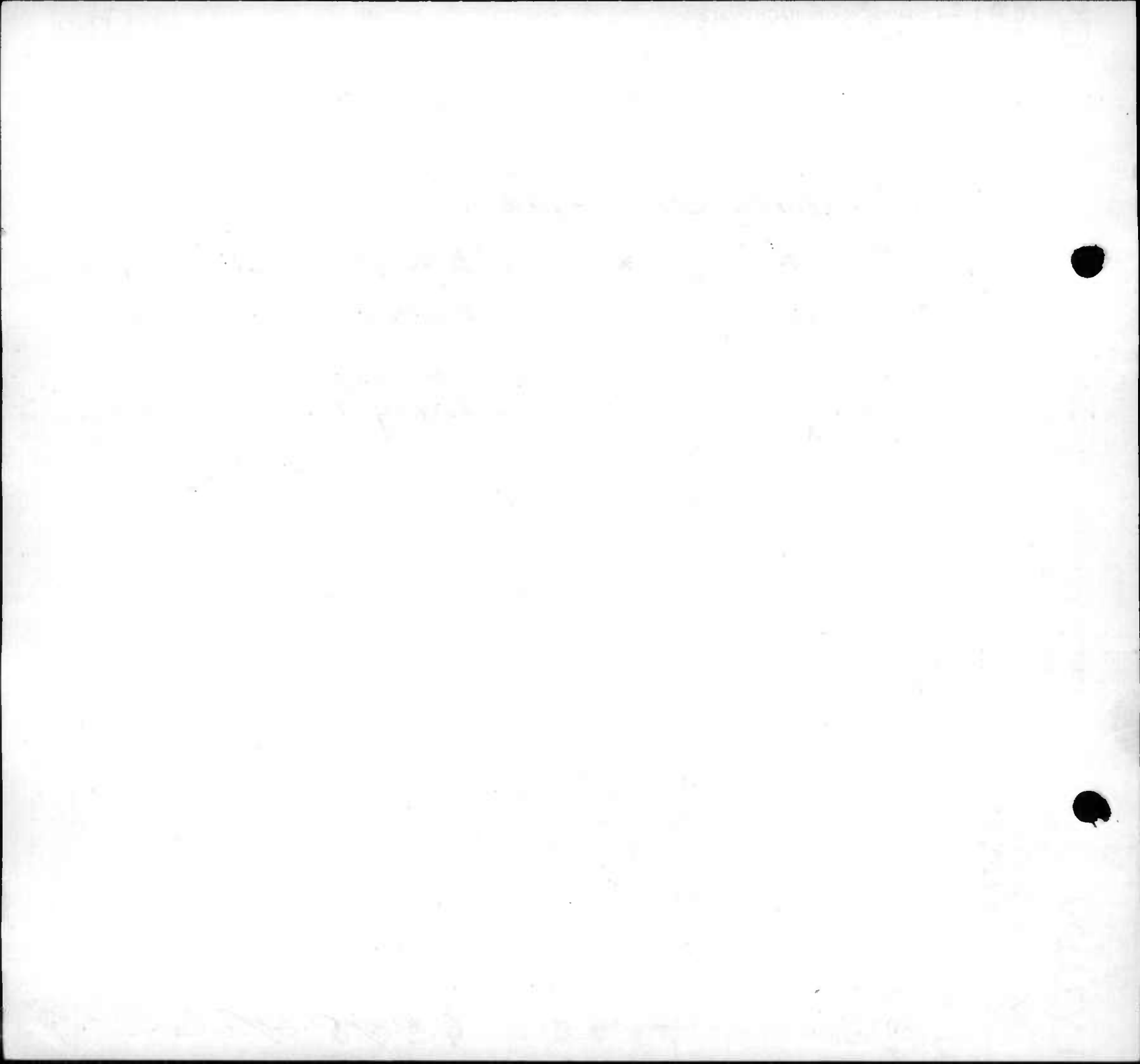
12/23/69 - 1910 Federal Census for Vivian Barnes. Age: 2yrs. 9 months.

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

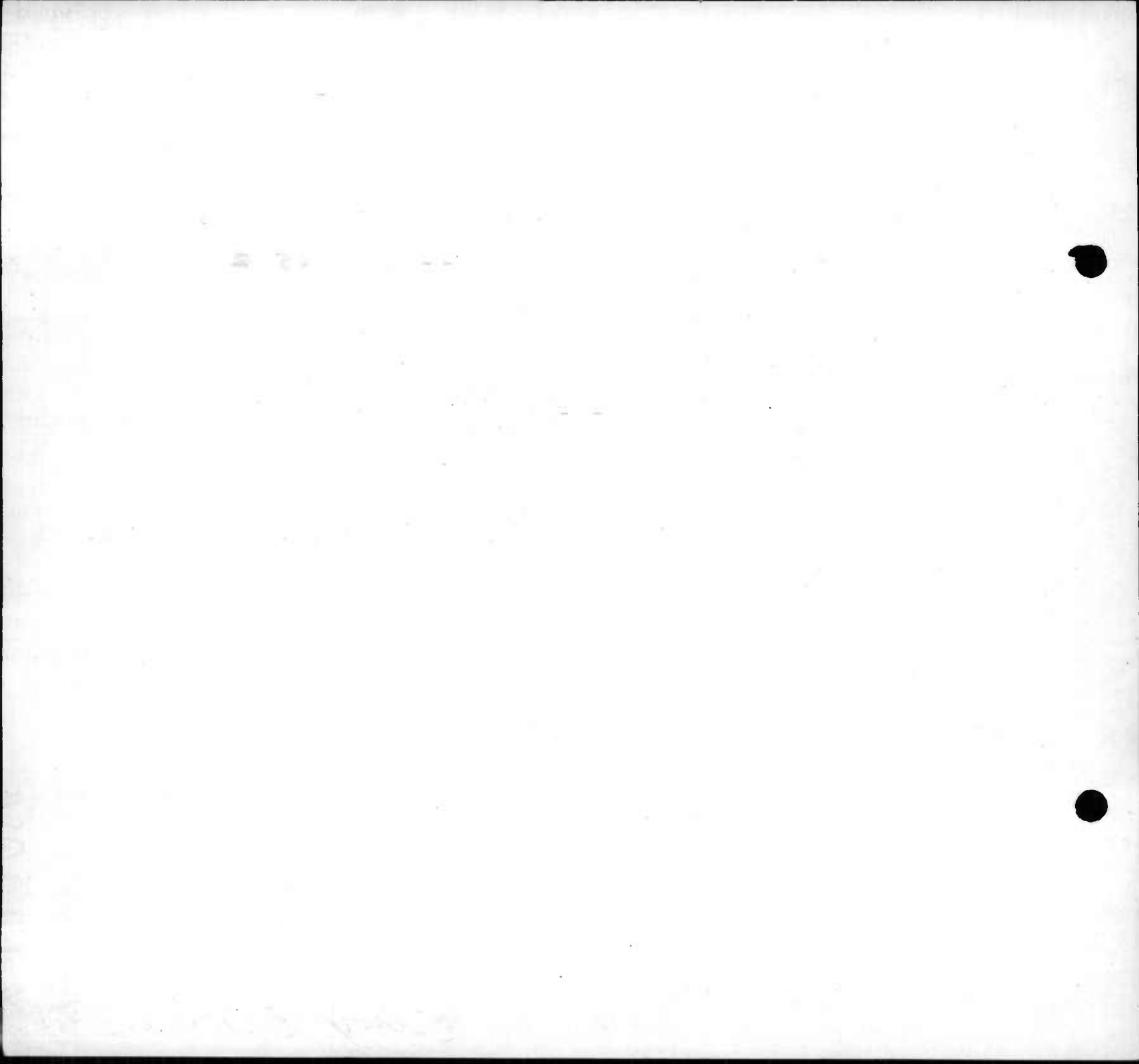
D-100 69 12289				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12289	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DUFFY, SARAH L				2. DATE AND HOUR OF DEATH 12-8-69 2 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN HOSPITAL OF MARYLAND 730 ASHBURTON STREET - 21216				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD- B. COUNTY BALTIMORE CITY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2606 WILMAN AVE.			
5. SEX F	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-20-98		9. AGE (In years last birthday) 71 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) WHARTON, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 220-14-6074		17. INFORMANT DAUGHTER ADDRESS NANCY PAGE 4032 Hilton St.	
18. 412.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Right cerebral embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) TO PROBABLE H.P.S.C.V.D (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12-1-1969 to 12-8-1969 , that (I) (we) last saw the deceased alive on 12-8-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Violeta R. Gamarra R.M.D.						23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) VIOLETA R. GAMARRA, R. M.D.						23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-69		24C. NAME OF CEMETERY or CREMATORY MT. ARBURN Cem.		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. Taylor R.D.		25C. FUNERAL DIRECTOR Edgar P. Wilson		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250		69 12290		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12290	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mary Jackson</u>				12-10-69 4:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u>				A. STATE <u>Maryland</u>		B. COUNTY <u>302</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing & Convalescent Center</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1400 East Baltimore Street</u>							
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-1904</u>	9. AGE (In years last birthday) <u>65</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Green</u>			14. MOTHER'S MAIDEN NAME <u>Coaker</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>219-07-4410</u>		17. INFORMANT <u>Jean Smith</u>		ADDRESS
18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>arteriosclerotic heart disease</u> (B) <u>generalized arteriosclerosis</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> 19 <u>69</u> to <u>12/10</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12/10</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>ae Martin</u>				23B. DATE SIGNED <u>12/11/69</u>		Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <u>ALLAN H. MACHT MD</u>				23D. ADDRESS <u>2 E Real St Balto, Md 21202</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>12-13-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel Cat</u>		24D. LOCATION (City, town, or county) (State) <u>Balto Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 12 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>E. Brody</u>		ADDRESS <u>O. Wilson</u>	



B-650

69 12291

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12291

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Herbert D. Brown		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 1510 Abbotston St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 8 1969 11:25A.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 907	
9. DATE OF BIRTH Sept 29 1940		10. AGE (in years last birthday) 59	
11. BIRTHPLACE (State or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-01-588	
18. INFORMANT Lillian Smith		ADDRESS	
19. 412.4 + 161.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		Carcinoma of larynx with metastasis of cervical lymph nodes	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-8-69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-69	
24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem		24D. LOCATION (City, town, or county) (State) Balto Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 12 1969		25B. NAME OF REGISTRAR Robert E. Fisher, R.D.	
25C. FUNERAL DIRECTOR Charles D. Wilson		ADDRESS 1000 Brambley Dr	

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69 12292

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12292

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) VERNON EUGENE KNAPP		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> December 5, 1969		Month Day Year Hour December 5, 1969 9:55 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION University Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 5, 1969 9:55 P.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 63-00	
6. SEX Male	7. RACE White	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Jessup	
9. DATE OF BIRTH JUNE 9, 1939		10. AGE (In years last birthday) 30		E. STREET AND NUMBER Maryland House of Correction	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME VERNON RENO KNAPP	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HANDMAN		14B. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		15. MOTHER'S MAIDEN NAME PAULINE REESE	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) U.S.		17. SOCIAL SECURITY NO. 217-34-4098		18. INFORMANT ADDRESS Mrs. PAULINE REESE 602 VALE AVE	
19. E860X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Methanol intoxication DUE TO, OR AS A CONSEQUENCE OF: (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) House of Correction		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Jessup, Maryland 63-00	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) Dec. 4 or 5, 1969		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Drank Duplicating fluid containing methyl alcohol	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-6-69					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-11-69		24C. NAME OF CEMETERY or CREMATORY LOUDON PARK	
24D. LOCATION (City, town, or county) (State) BALTO., Md.		24E. NAME OF REGISTRAR Robert E. Taylor, M.D.		24F. FUNERAL DIRECTOR ADDRESS 5444 BELAIR RD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS 5444 BELAIR RD.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> D-260 69 12293 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12293	
BIRTH NO. 1. NAME OF DECEASED (Type or Print) <u>JOAN L. DASHER</u>		2. DATE AND HOUR OF DEATH <u>12/10/69</u> <u>3⁰⁰ P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>KEY CIRCLE HOSPICE</u> <u>1214 EUTAW PLACE</u> <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>A.A. Co.</u> C. CITY OR TOWN <u>HARMON'S</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>RAILROAD AVENUE</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/4/1948</u>	9. AGE (In years last birthday) <u>21</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>EDGAR HOWARD</u>		14. MOTHER'S MAIDEN NAME <u>Alice Dean</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-52-8225</u>		17. INFORMANT <u>Richard L. Dasher</u> ADDRESS <u>RAILROAD AVE</u>	
18. <u>238.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>Tumor of hypothalamus</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Tumor of hypothalamus</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-5-69</u> to <u>12-10-69</u> , that (I) (we) last saw the deceased alive on <u>12-9-69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Richard R. Rigler</u>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12-10-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>RICHARD R. RIGLER</u>		23D. ADDRESS <u>1214 Eutaw Place</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/13/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Elkridge Md.</u>	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D. 9</u>	
25C. FUNERAL DIRECTOR <u>Singleton Funeral Home / Monroeville</u>		ADDRESS			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

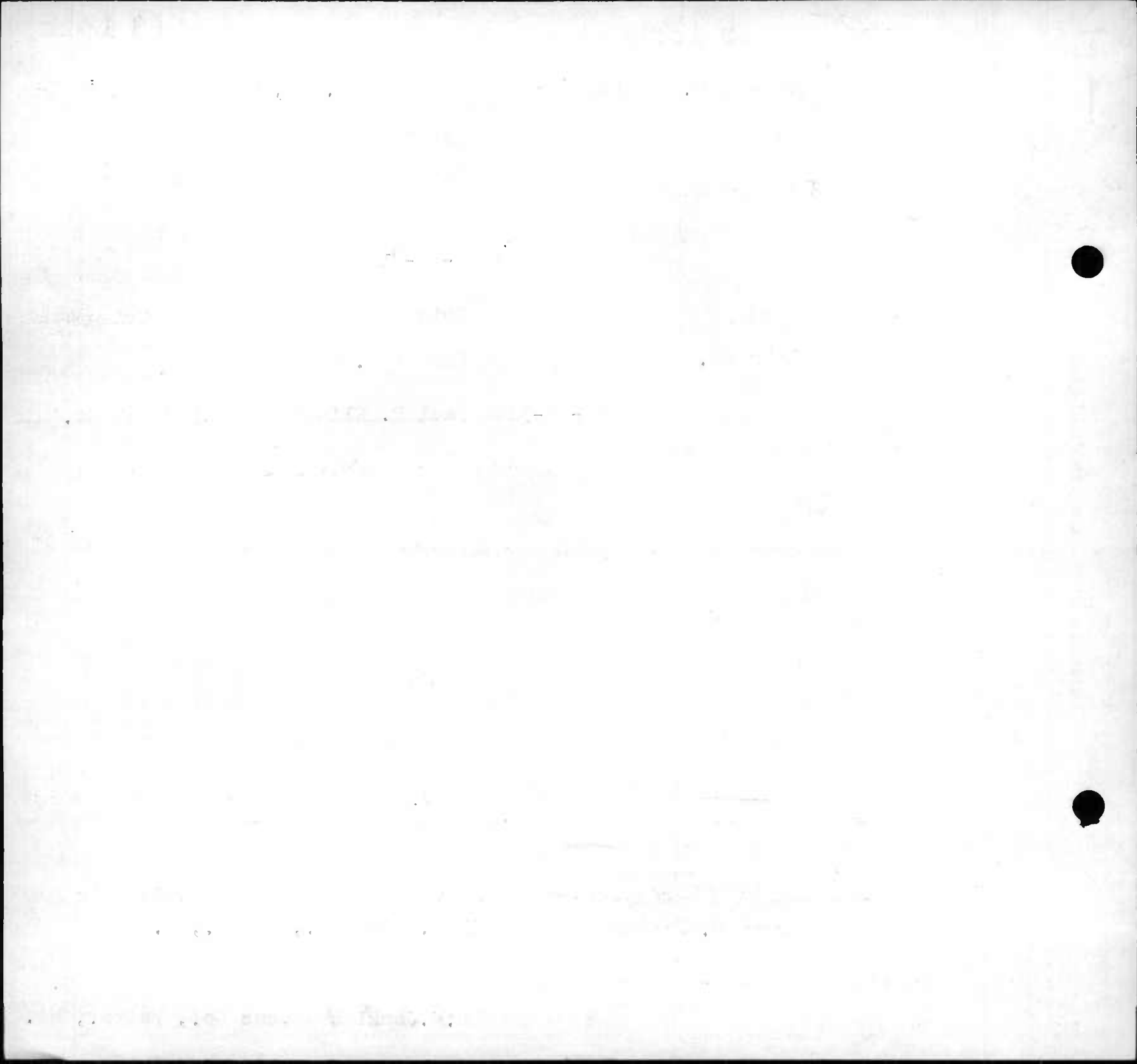
L-256 69 12294		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 69 12294	
BIRTH NO.		M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) Lilly B. Lachenmayer				9:15 PM Dec 8 1969 Dec 9 1969	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
00 Roland View Towers Apt. 911 Baltimore, Maryland 21211		Maryland Baltimore		1307	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)			
Baltimore		3838 Roland Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
Female	White	Widowed	5/15/84	85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Md.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
USA		Oscar H. Blanck		Marie C. Thiess	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO NONE		220-44-2710		Rd. Mrs. Gordon M. Holland-103 N. Rolling	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
437.9 I		(A) Bronchopneumonia		3 days	
ANTECEDENT CAUSES		(B) Cerebral Atherosclerosis		5 yrs.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
None				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
None		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (the physician) attended the deceased from OCT 8 1968 to Nov 8 1969 , that (I) (we) last saw the deceased alive on Dec 8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Alan B. Cohen				12/9/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Alan B. Cohen				3501 St. Paul Street Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		12/11/69		Greenmount Cemetery Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 15 1969		Alan B. Cohen		Agon Donovan - 3818 Roland Ave.	

Paul Street Bal

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

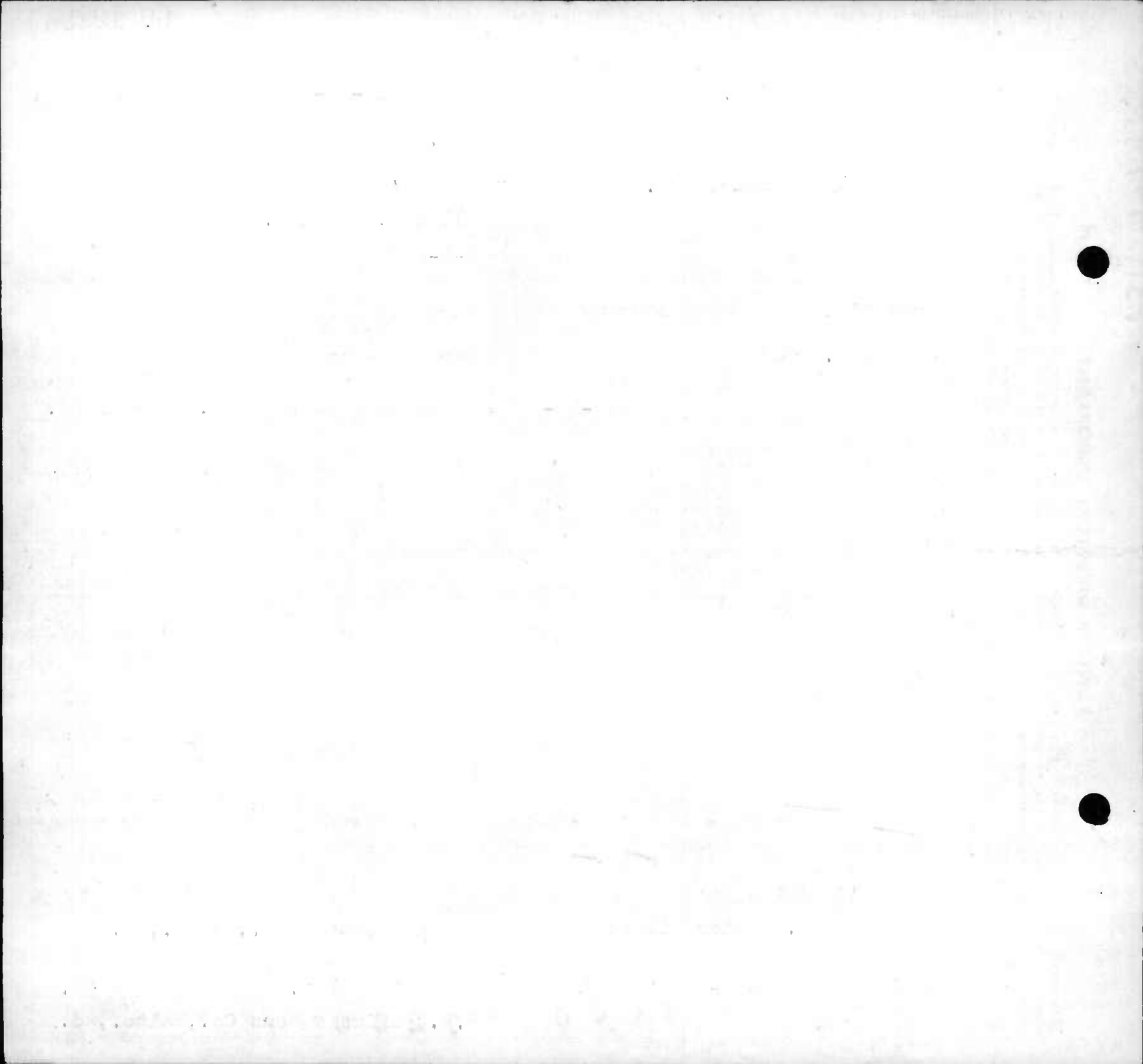
S-435		69 12295		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12295	
BIRTH NO.				1. NAME OF DECEASED (Type or Print)			
				IMOGENE D. SELDEN			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 00 3405 Greenway				Dec. 12, 1969 1:45 A.M.			
				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
				Maryland		1202	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3405 Greenway			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years lost birth day)	
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-17-81		88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Never Employed						Ohio	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Charles Selden Jr.				Carrie B. Stork			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				705-10-3261		Paul R. Klinder 13 South St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) I 1830 I CAUSE OF DEATH Carcinoma of Vagina (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ovarian Ca. (B) DUE TO, OR AS A CONSEQUENCE OF: (C).....				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 yr.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (the hospital) attended the deceased from May 10 1966 to Dec 12 1969, that (I) (the doctor) last saw the deceased alive on Dec. 10 1969 and that in (my) (the doctor's) opinion death occurred on the date and hour and from the causes stated above. (I) (the doctor) (did not) view the body after death.							
23A. SIGNATURE						23B. DATE SIGNED	
Norman R. Freeman MD						12/12/69	
23C. PHYSICIAN'S NAME (Type)						23D. ADDRESS	
						11 W. 29th St., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Cremation		12-13-69		Greenmount		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
DEC 15 1969		Cecil E. Selden		H.W. Jenkins & Sons Co., Balto., Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
HENRY M. BOND		12-12-69		1:00 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 4135 Roland Ave.		A. STATE Md.		B. COUNTY 1307	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4135 Roland Ave.			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-3-1882	9. AGE (In years last birthday) 87	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Photocopy	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joshua B. Bond		14. MOTHER'S MAIDEN NAME Sarah Carson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-14-3591A		17. INFORMANT Calhoun Bond 1001 St. Georges Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASE OR CONDITION, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Occlusion (B) DUE TO, OR AS A CONSEQUENCE OF: Coronary Heart Disease (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 3 mos.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-3-69 to 12-12-69, that (I) (we) lost saw the deceased alive on 12-1-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE E. Hunter Wilson				23B. DATE SIGNED 12-12-69	
23C. PHYSICIAN'S NAME (Type) E. Hunter Wilson				23D. ADDRESS Medical Arts Bldg., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-13-69		24C. NAME OF CEMETERY or CREMATORY Lorraine Park	
24D. LOCATION Balto.		24E. LOCATION Md.		24F. LOCATION Md.	
25A. DATE REC'D. BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR E. Hunter Wilson		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co., Balto., Md.	



FUNERAL DIRECTOR: IMPORTANT

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C-623 69 12297		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12297	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Carroll Crockett		Dec. 10, 1969 11 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE Maryland		
Long Green Nursing Home			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
90			E. STREET AND NUMBER 4822 Roland Ave.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-26, 1893	9. AGE (In years lost birthday) 76	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Own Business - Seafood Canning-Ret'd.			Crisfield, Maryland		U.S.A.
13. FATHER'S NAME A. R. Crockett			14. MOTHER'S MAIDEN NAME Lillian Lawson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 245-20-3203	17. INFORMANT ADDRESS Mrs. Thomas Cover III-Garrison, Md.		
18. 204.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH Lymphatic leukemia, chronic		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.)	(Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 1958 to Dec 10 1969, that (I) (we) last saw the deceased alive on Dec 8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. William G. Helfrich			23B. DATE SIGNED 11-Dec 69		23C. PHYSICIAN'S NAME (Type)
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12-12-1969	24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery	24D. LOCATION (City, town, or county) (State) Pikesville, Balto.Co., Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor	25C. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co.		ADDRESS 4205 York Road Balto., Md. 21212

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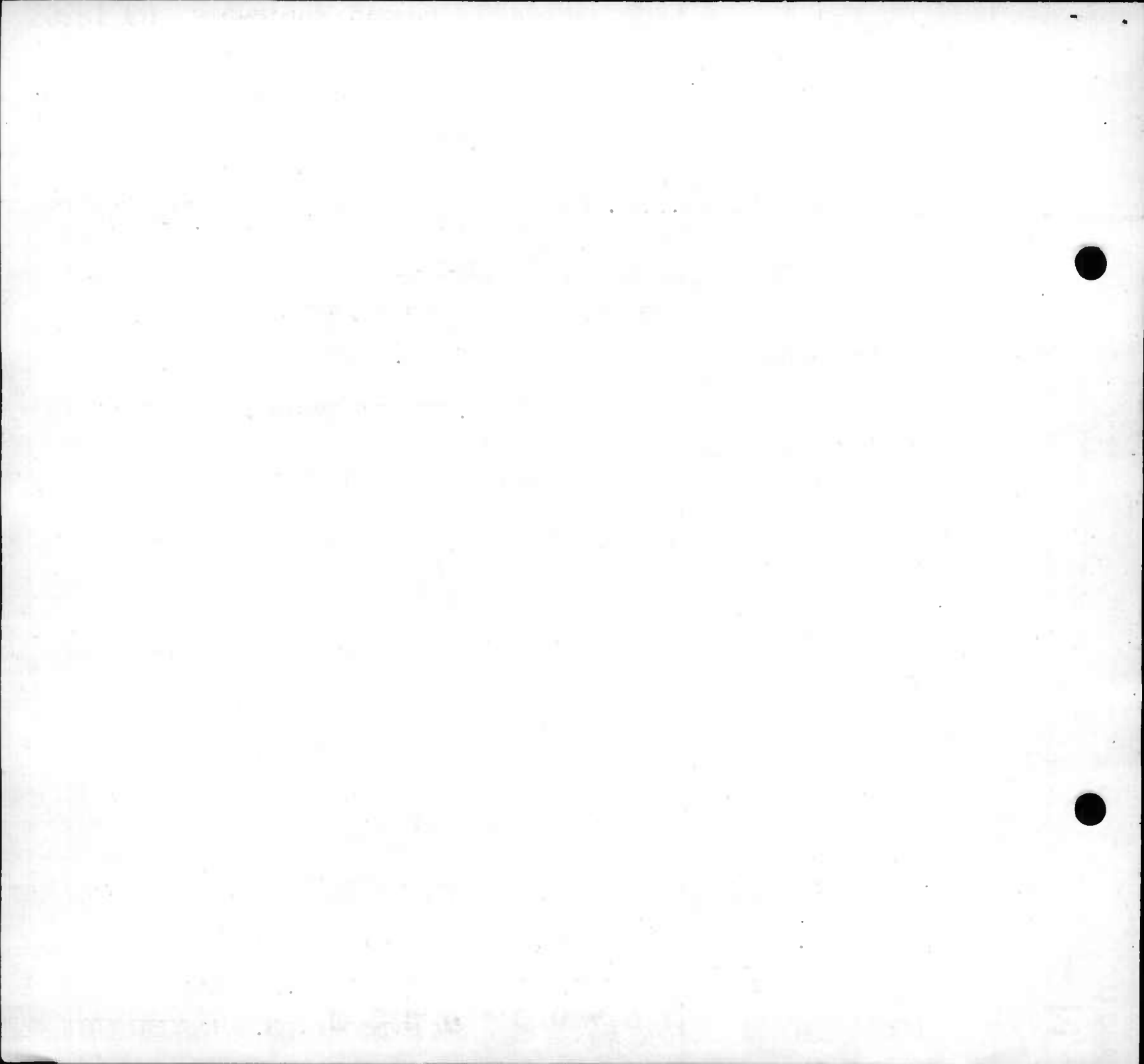
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

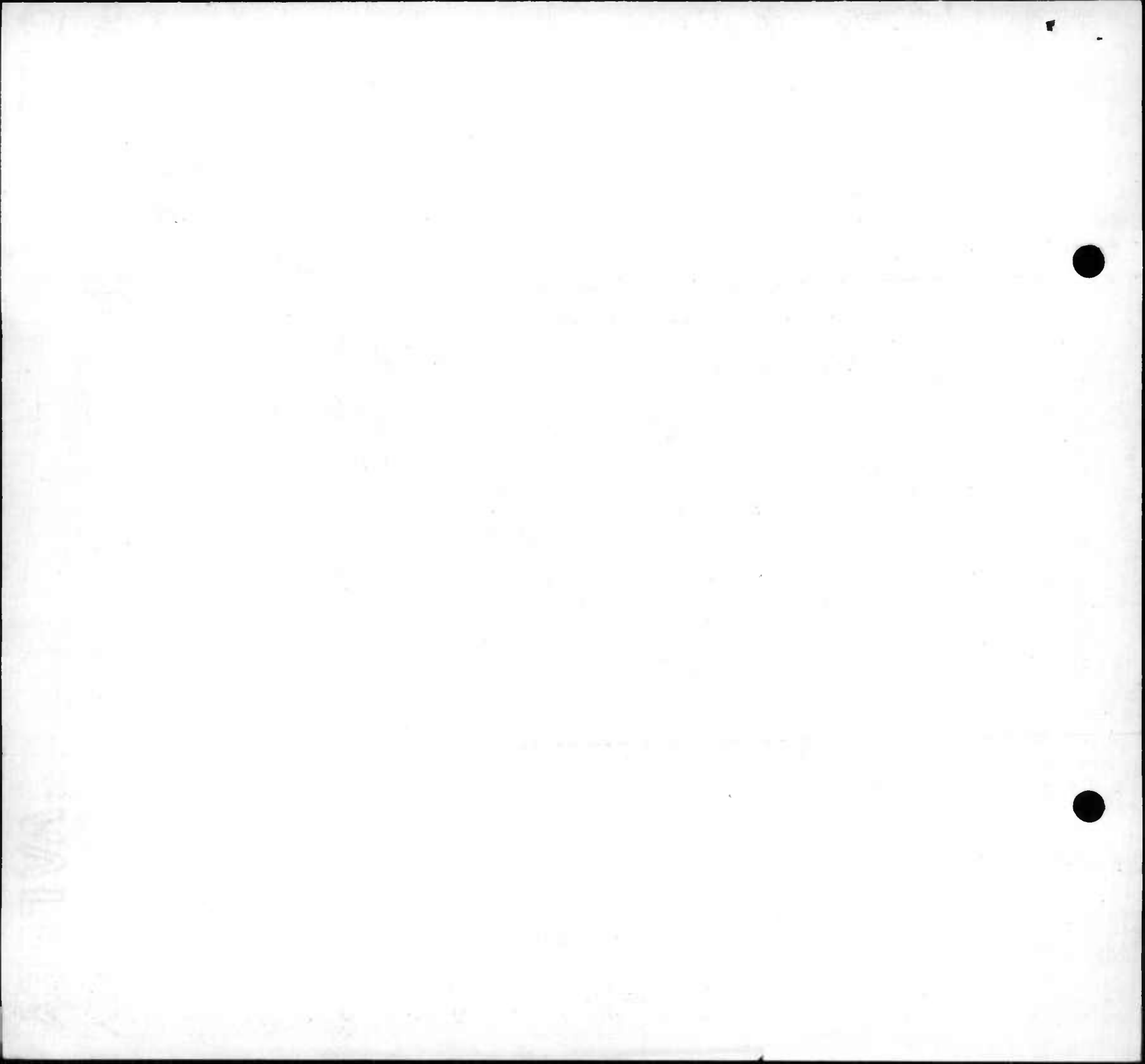
H-635		69 12298		BALTIMORE CITY HEALTH DEPARTMENT		69 12298	
CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) FRIEDA KEMPER HARTMAN				DECEMBER 9, 1969 2 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
00 ARLINGTON PARK APTS 6701 PARK HEIGHTS AVE., APT. 4 F				MARYLAND		2730	
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER ARLINGTON PARK APARTMENTS 6701 PARK HEIGHTS AVE., APT. 4-F #15			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	10-16-83	86			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		AT HOME		BALTIMORE, MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
DAVID KEMPER				EMMA S. SOLOMON			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO				MR. FREDERICK NASSAUER, 3903 NAYLOR LANE #08			
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		1 hr	
				Pulmonary Edema			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		2 hrs	
				Coronary Occlusion			
				(C) Arteriosclerotic Heart Disease		20 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Chronic Hepatitis		15 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
D				No			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, form, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 7/25 1958 to Dec. 9 1969, that (I) (we) last saw the deceased alive on Dec. 4 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Jonas Cohen</i>				23B. DATE SIGNED		Dec. 9, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
DR. JONAS COHEN				6702 PARK HEIGHTS AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		12-11-69		HAR SINAI, EDISON HWY & EDDMAN AVE., MARYLAND			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 15 1969		J. E. Cohen, M.D.		SOL LEVINSON & BROS.		6010 REISTERSTOWN ROAD	



FUNERAL DIRECTOR: IMPORTANT

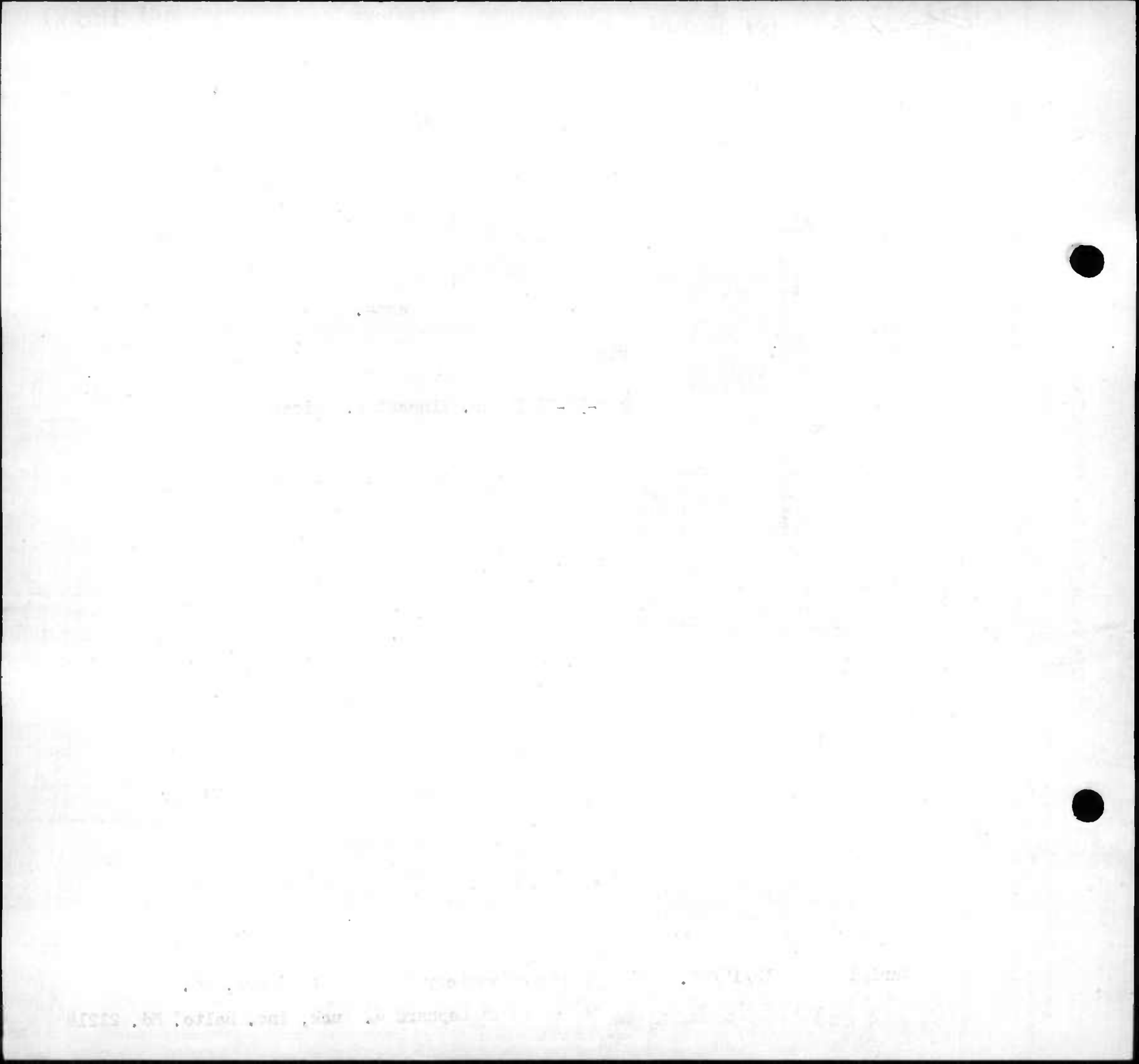
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> S-314 69 12299 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12299	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Stiefel, Rose		2. DATE AND HOUR OF DEATH 12/9/69 7:05 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pleasant Manor Nursing Home 46-15 Park Hotel Avenue Baltimore 81015			E. STREET AND NUMBER 5523 Lynview Ave #15		
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/7/82	9. AGE (In years last birthday) 87	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Max Stern		14. MOTHER'S MAIDEN NAME Rachel ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Abram Stiefel ADDRESS 3510 Hardemire Rd #08	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Broncho Pneumonia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. HAEMID Diabetes Mellitus			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days 10 years 10 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/5 19 60 to 12/9 19 69 , that (I) (we) last saw the deceased alive on 12/9 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Isaiah Zinberg M.D. DEGREE				23B. DATE SIGNED 12/10/69	
23C. PHYSICIAN'S NAME (Type) ISRAEL ZINBERG DEGREE				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-10-69		24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			
25B. NAME OF REGISTRAR John E. Fisher, M.D.		25C. FUNERAL DIRECTOR 6010 ADDRESS Belair Road, Baltimore, Maryland			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-126 69 12300		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12300	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) <u>Evelyn R. Spicer</u>			2. DATE AND HOUR OF DEATH <u>11 Dec 1969</u> <u>1 750 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>907</u>		
5. SEX <u>F</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>5/15/15</u> 9. AGE (In years last birthday) <u>54</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			11. BIRTHPLACE (State or foreign country) <u>Penna.</u>		
13. FATHER'S NAME <u>?</u> <u>Kyle</u>			14. MOTHER'S MAIDEN NAME <u>?</u> <u>Busler</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>220-34-7255</u>		
17. INFORMANT <u>Mr. Vincent J. Spicer</u>			ADDRESS <u>(Same)</u>		
18. <u>144X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Recurrents CA of</u> <u>Fluor of Mouth</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 MONTHS</u>		
19A. DATE OF OPERATION <u>MAR 1968</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CA of Mouth</u>		
20A. AUTOPSY? (Yes or No) <u>NO</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <u>5 Dec</u> 19 <u>69</u> to <u>11 Dec</u> 19 <u>69</u> , that (1) (we) lost saw the deceased alive on <u>5 Dec</u> 19 <u>69</u> and that in (my) (aur) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edward J. Fynn Jr.</u>			23B. DATE SIGNED <u>11 Dec 1969</u>		
23C. PHYSICIAN'S NAME (Type) <u>Edward J. Fynn Jr.</u>			23D. ADDRESS <u>Union Memorial Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/15/69.</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>			
25B. NAME OF REGISTRAR <u>John E. Tully, Jr.</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u>			



1

T-525 69 12301

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12301

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MAY B. TENNYSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> December 10, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 10, 1969 1:20 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Feb. 13, 1907.		10. AGE (In years last birthday) 62	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired File Clerk		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 218-10-2543	
18. INFORMANT Mr. James W. Booze, Fishing Creek, Md.		ADDRESS	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.41 Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21. AUTOPSY? (Yes or No) Yes	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/12/69.	
24C. NAME OF CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert L. Taylor, M.D.	
25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		ADDRESS	

1930

EXAMINER'S CERTIFICATE OF DATA

1930

Thompson House

Thompson

Feb. 15, 1930

Thompson House

Thompson House

1930-10-10, at, Thompson House, Thompson House, Md.

No.

Thompson House, Thompson House, Thompson House, Md.

Thompson House, Md.

Thompson House, Md.

12/12/30

Thompson

Thompson House, Md.

G-653

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12302

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

ROOSEVELT (GRUNDY) GRANDY

2. DATE
OF
DEATHKnown ☒ Estimated ☐

Month

Day

Year

Hour

12

11

69

3:25p M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Provident Hospital D.O.A.

3. DATE
PRONOUNCED DEAD

December 11, 1969

3:25 p.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

Balto.

YES ☐NO ☐

6. SEX

7. RACE

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

Male

Negro

9. DATE OF BIRTH

1/31/49

10. AGE (in years
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

11. BIRTHPLACE (State or foreign country)

Baltimore, Md

12. CITIZEN OF
WHAT COUNTRY?

E. STREET AND NUMBER

2118 Druid Hill Ave.

13. FATHER'S NAME

Roosevelt Grandy, Sr

14A. USUAL OCCUPATION (Give kind of work
done during most of working life even if retired)

Construction

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Roberta P Hawkins

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

Mrs Roberta P Hawkins, same

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Stabwound of the chest
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

Tavern

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

Ray Scott's Bar B-Q 2051 Pennsylvania Ave.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

12 11 69 3:15p.m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject stabbed during argument

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE

EXAMINER'S

NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/11/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/15/69

24C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cemetery

24D. LOCATION

Baltimore Md

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Adolphus Halstead 1206 W

ADDRESS

North Ave



1

69 12303

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12303

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

WILLIAM SCHWESSINGER

2. DATE OF DEATH
Known ☒ Estimated ☐ Month Day Year Hour
12 11 69 7:55 a.m.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Union Memorial Hospital D.O.A.

3. DATE PRONOUNCED DEAD
Month Day Year Hour
December 11, 1969 7:55 a.m.5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
A. STATE B. COUNTY

Maryland

B. COUNTY

2702

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

JAN. 3, 1908

10. AGE (In years last birthday)

61

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2907 E. Cold Spring Lane

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Edward Schwessinger

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

ACCOUNTANT

14B. KIND OF BUSINESS OR INDUSTRY

KERR-McGEE Co.

15. MOTHER'S MAIDEN NAME

MARGARET SCHWINN

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

215-05-5821

18. INFORMANT

MRS. VERA SCHWESSINGER

ADDRESS

(SAME)

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

Arteriosclerotic cardiovascular disease

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Isidore Mihalakis, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/12/69

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

12/15/69

24C. NAME OF CEMETERY or CREMATORY

KRIEDERS CEMETERY

24D. LOCATION (City, town, or county)

WESTMINSTER MD.

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

25B. NAME OF REGISTRAR

Robert E. Farber, M.D.

25C. FUNERAL DIRECTOR

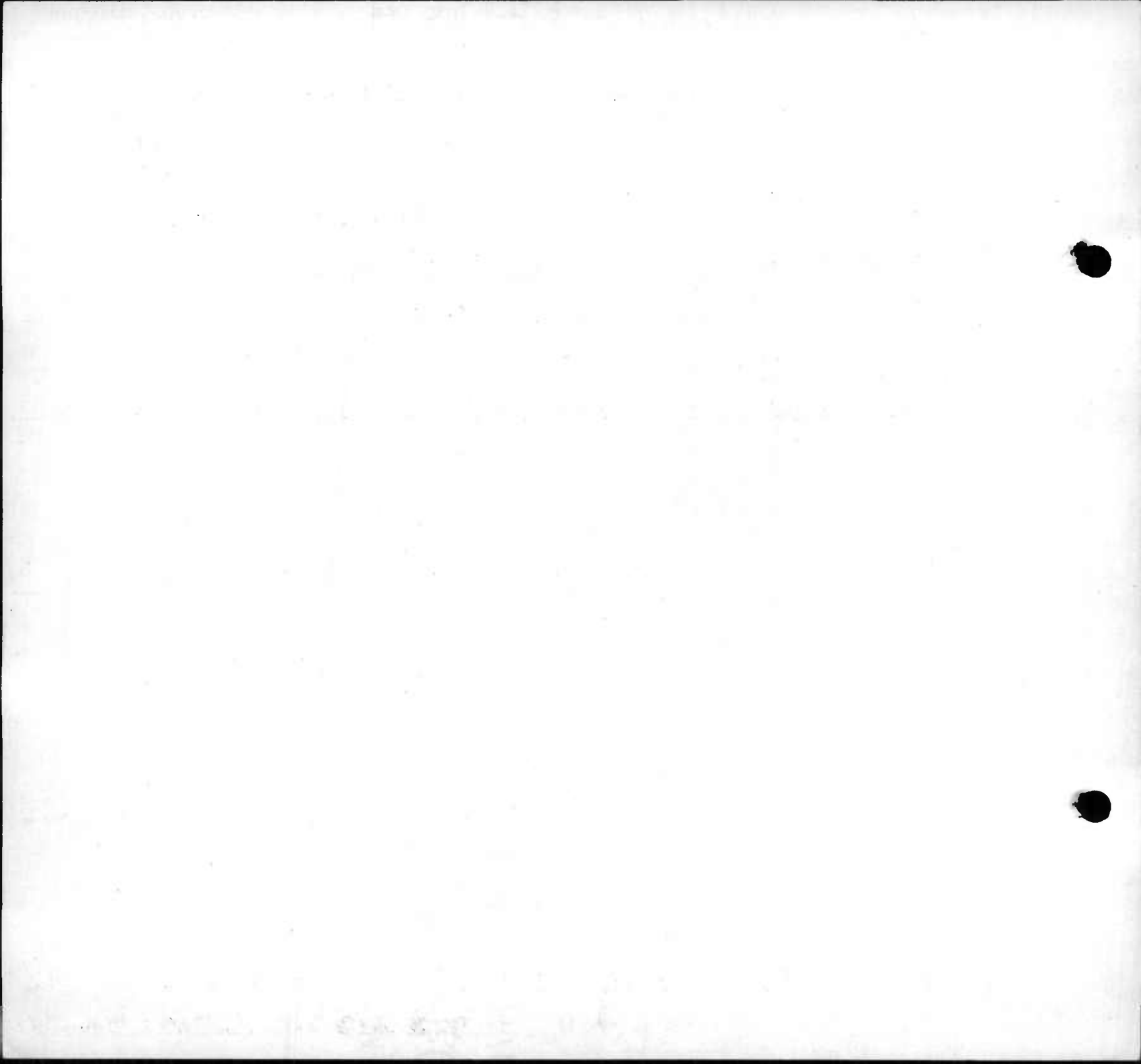
LEONARD J. Ruck, Inc. BALTO. MD. 21214

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-524		69 12304		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12304	
1. NAME OF DECEASED (Type or Print) HARRY G. Angle				2. DATE AND HOUR OF DEATH December 14th 1969 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2536 E. Fayette Street				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 602 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2536 E. Fayette Street			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1893	9. AGE (In years last birthday) 74	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Baltimore
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Machine Operator		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Louis Angle				14. MOTHER'S MAIDEN NAME Mary Horkert			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. 216-14-7829		17. INFORMANT Harriet Angle		ADDRESS 2536 E. Fayette St	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 441.2.1 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Emphysema + Chron. Bronchitis				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac Arrest			
				(B) DUE TO, OR AS A CONSEQUENCE OF: Atherosclerosis Cardiovascular Disease			
				(C) DUE TO, OR AS A CONSEQUENCE OF: Abdominal - Aortic Aneurysm -			
19A. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4/28 to 12/14/69 19 69 and that (I) (we) lost saw the deceased alive on 12/9 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph S. Blum				23B. DATE SIGNED 12/15/69			
23C. PHYSICIAN'S NAME (Type) JOSEPH S. BLUM MD				23D. ADDRESS 1115 N. CALVERT ST.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/17/69		24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) 5561 Frederick Ave Balto Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Fredrick D. Muller		ADDRESS 3018 E. Monument St	



R-200

69 12305

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12305

BIRTH NO.

1. NAME OF DECEASED (Type or Print) LLOYD H. RICHEY		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> December 5, 1969		Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Church Home and Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year December 5, 1969		Hour 3:20 P.
6. SEX Male		7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. DATE OF BIRTH Sept. 5, 1909		10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) VA.
12. CITIZEN OF U.S.A.		13. FATHER'S NAME John W Richey		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) John Hopkins Hosp. ATT.
15. MOTHER'S MAIDEN NAME Bessie Carter		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.
18. INFORMANT Ruby Richey		ADDRESS SAME VA.		
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE Charles S. Springate		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12-6-69
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-13-69		24C. NAME OF CEMETERY or CREMATORY Belair Memorial Gardens
24D. LOCATION (City, town, or county) (State) Belair, Maryland		24E. FUNERAL DIRECTOR James F. Bruzdinski		
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor		

TO THE HONORABLE CHIEF OF POLICE
CITY OF NEW YORK
FROM THE
NEW YORK CITY POLICE DEPARTMENT
RE: [Illegible]

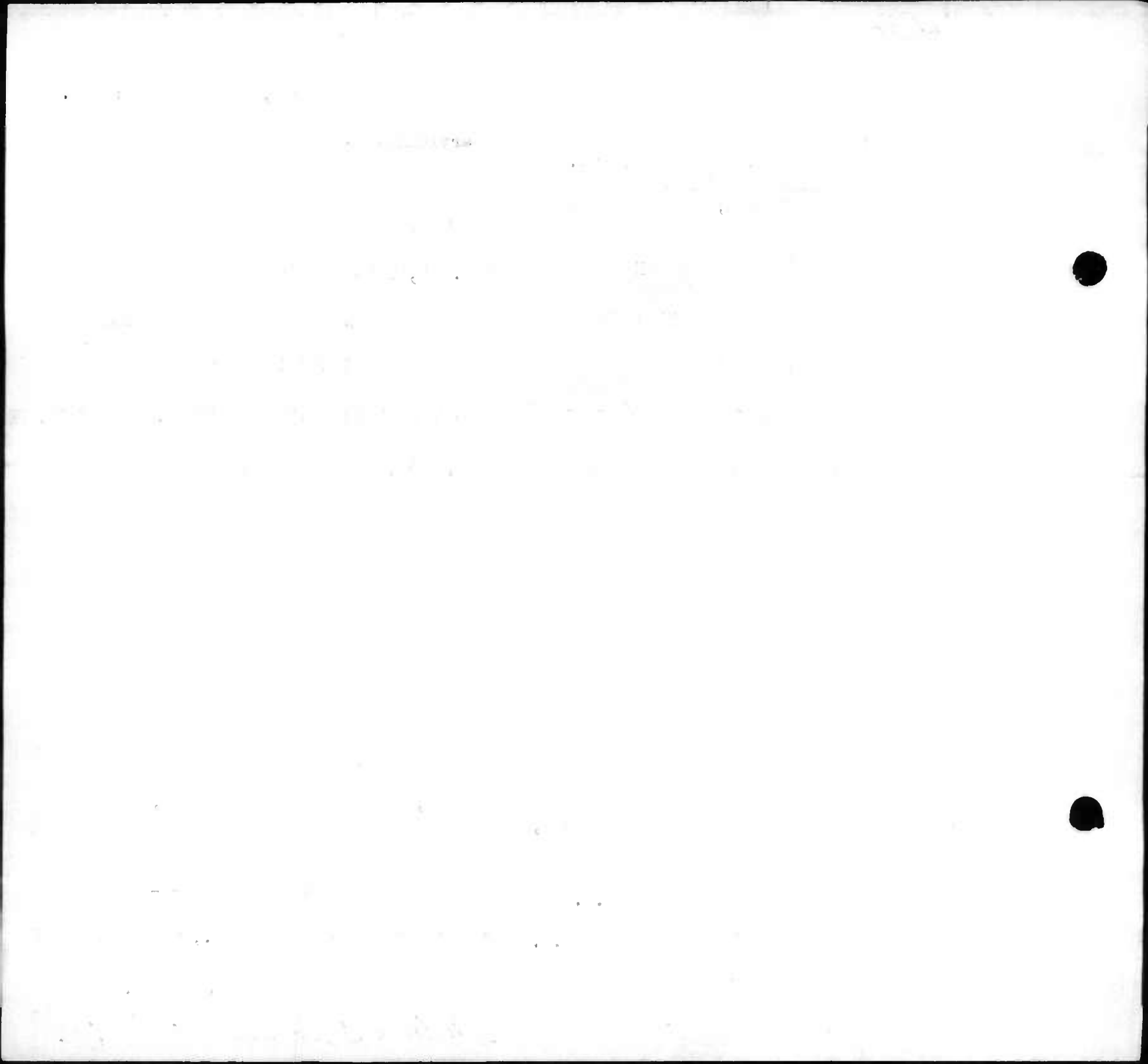
[Illegible text follows, including what appears to be a subject line and a body of text, but it is too faint to transcribe accurately.]

Very respectfully,
[Illegible Signature]

[Illegible text at the bottom of the page, possibly a date or reference number.]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

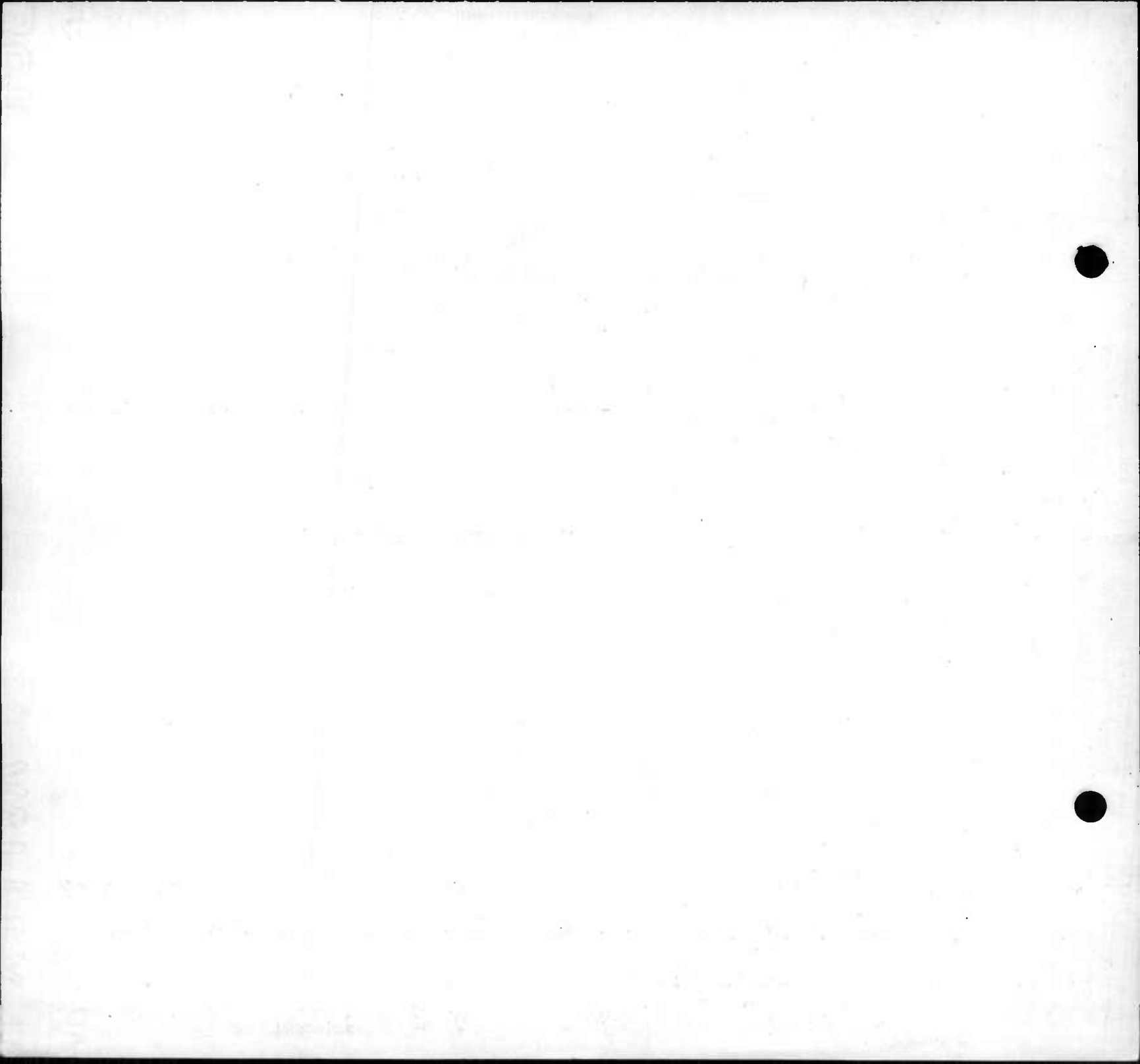
H-300		69 12306		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12306	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Hilton Haywood				2. DATE AND HOUR OF DEATH December 3, 1969 7:20 a. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2532					
FULL NAME OF HOSPITAL OR INSTITUTION 39 PROVIDENT Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				C. CITY OR TOWN Baltimore				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 2206 Round Road									
5. SEX Male		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 25, 1916		9. AGE (in years last birthday) 53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10B. KIND OF BUSINESS OR INDUSTRY DOCK WORKER		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL HAYWARD				14. MOTHER'S MAIDEN NAME CORNELIA HENSON					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I I				16. SOCIAL SECURITY NO. 214-07-8484		17. INFORMANT BRENDA HAYWARD 1031 CAMELIA CR. CAMBRIDGE, MD			
18. 436.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE Cerebrovascular DUE TO, OR AS A CONSEQUENCE OF: accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December 1, 19 69 to December 3, 19 69 that (I) (we) last saw the deceased alive on December 3, 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Jaredo M.D. DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-9-69			
23C. PHYSICIAN'S NAME (Type) Jaredo M.D. DEGREE				23D. ADDRESS 1514 Division Street Bal to., Maryland 21217					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/13/69		24C. NAME OF CEMETERY OR CREMATORY BETHEL		24D. LOCATION (City, town, or county) CAMBRIDGE		24D. LOCATION (City, town, or county) DOR. MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969				25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Frederick C. Blair		25D. ADDRESS ST. CLAIR F. HOME CAMBRIDGE, MD.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Bodily burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

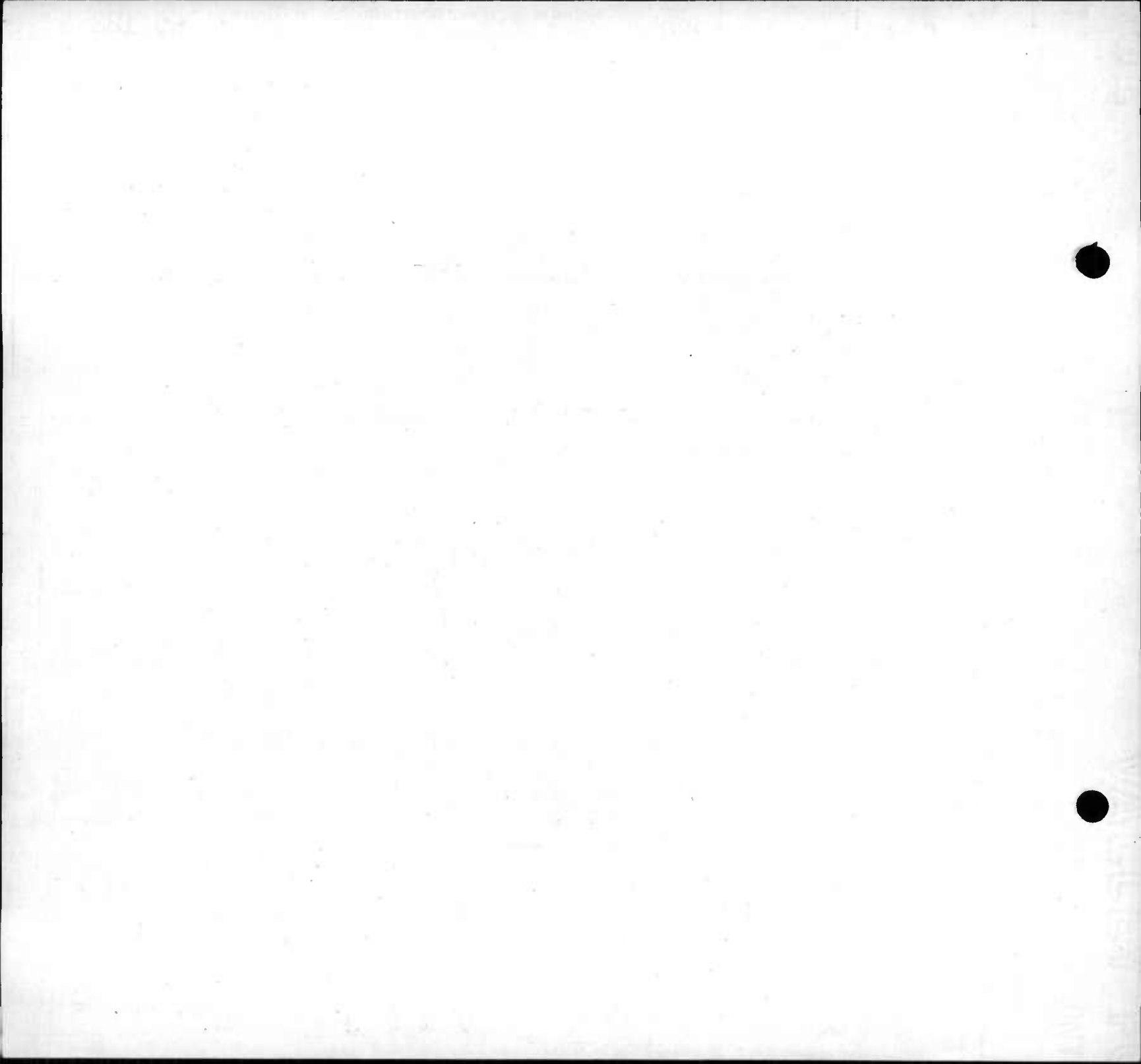
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12307	
<div style="display: flex; justify-content: space-between;"> K-500 69 12307 CERTIFICATE OF DEATH </div>					
BIRTH NO.		2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)		Dec. 10, 1969			
ALICE IRENE KANE					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
4520 Clareway		Md. 21213			
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		4520 Clareway			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
female	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10/15/77	92	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		at home		Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thomas Kane			Lydia Kane		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		220-46-7603		21206	
		Walter Wal trop, nephew, 4854 Bowland Av.			
18. 410.91		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		10-15 days	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		Carmay Thrombosis			
ANTECEDENT CAUSES		(B) Arteriosclerosis, CV Disease		5 yrs	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 9 Dec 19 69 to 9 Dec 19 69 , that (I) (we) last saw the deceased alive on 9 Dec 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Howard Goodman				23B. DATE SIGNED	
				12/12/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
HOWARD GOODMAN MD.		8604 HARFORD RD. BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/13/69		Holy Redeemer Cemetery	
				Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 15 1969		Robert E. Taylor, M.D.		Schimmek Funeral Home, Inc. 3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

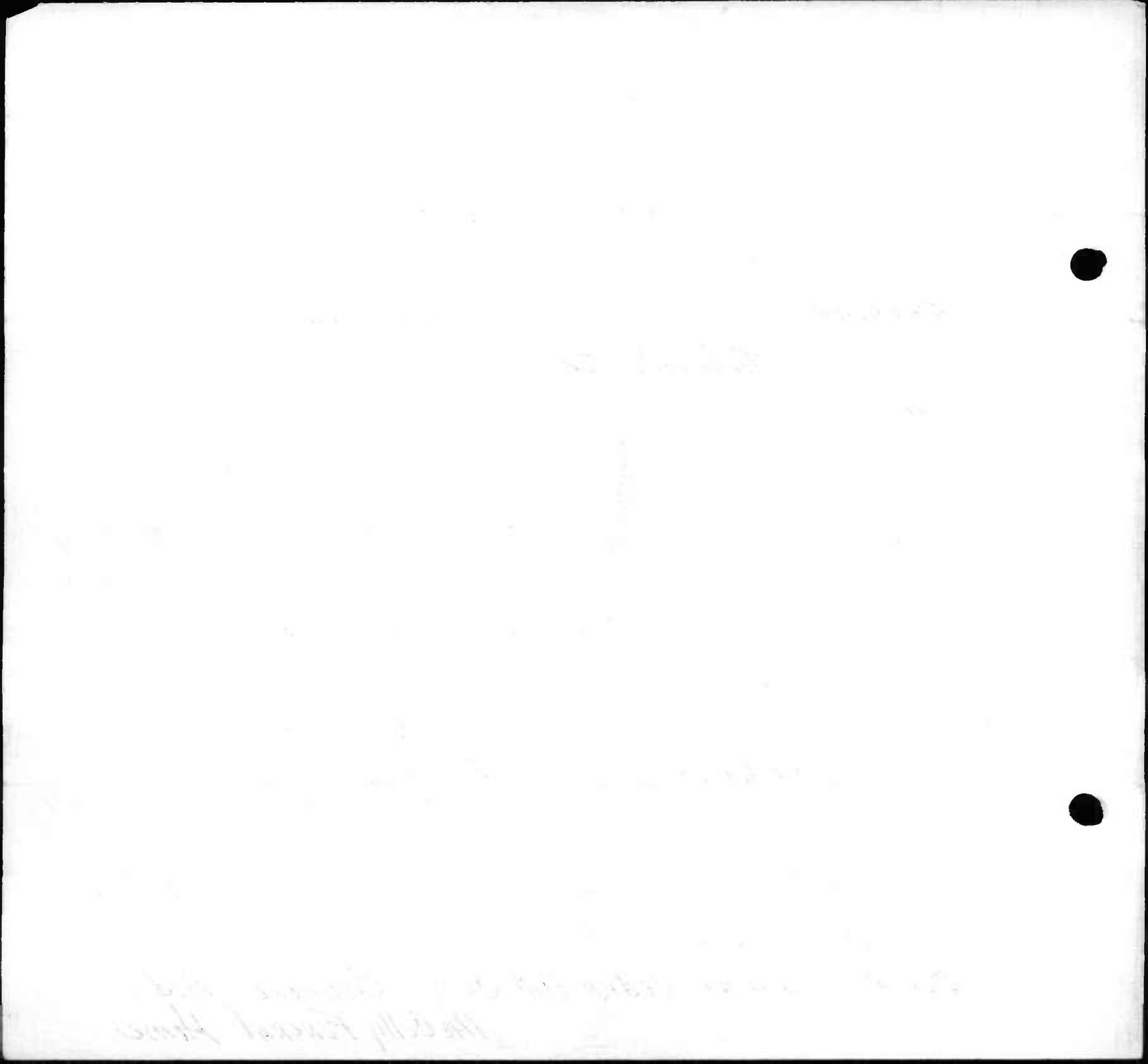
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12308</u>	
M-624		69 12308		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		George JOSEPH MARSHALL		12-12-69 3.45 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 THE JOHNS HOPKINS HOSPITAL				A. STATE MARYLAND	
				B. COUNTY BALTIMORE CITY 702	
				C. CITY OR TOWN BALTIMORE	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 809 N. LAKEWOOD AVE 21205	
5. SEX MALE	6. RACE WHITE	7. MARRIAGE <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH 2-21-02	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Mgr.		10B. KIND OF BUSINESS OR INDUSTRY Food Fair Stores		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME JAMES MARSHALL				14. MOTHER'S MAIDEN NAME AGNES VANICEK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 217-16-4527		17. INFORMANT 917 S. Bouldin St. ADDRESS Joseph Marshall, son,	
18. <u>174 X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Carcinoma of throat</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Cachexia</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/9/69</u> 19 <u>69</u> to <u>12/12</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12/12</u> 19 <u>69</u> and that in (my) (four) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Harvey G. Klein</u>				23B. DATE SIGNED <u>12/12/69</u>	
23C. PHYSICIAN'S NAME (Type) HARVEY G. KLEIN				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR Schimmek Funeral Home, Inc. 2801 E. Madison St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

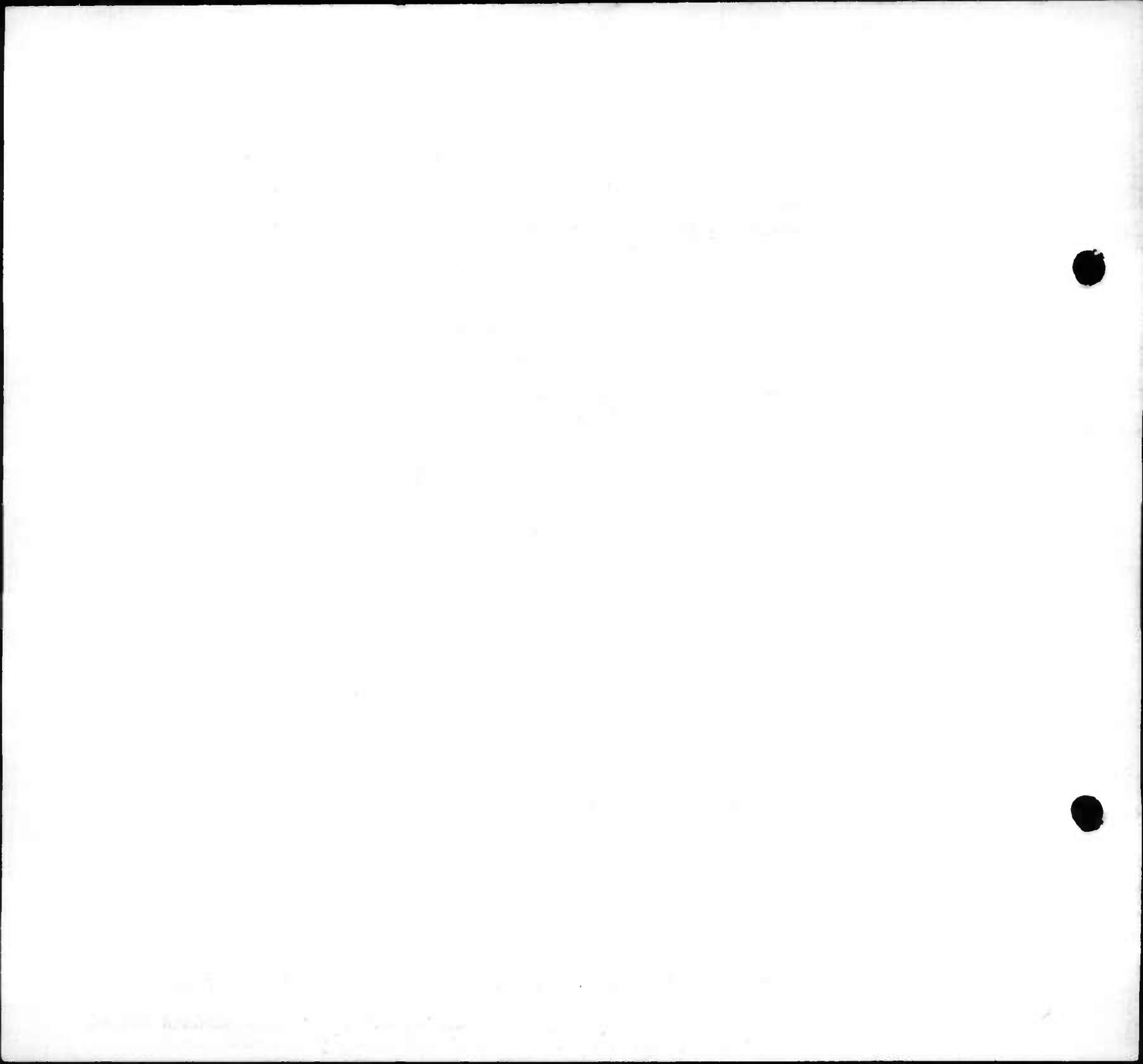
T-611		69 12309		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12309	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>TURBEVILLE, WILLIAM THOMAS</u>				2. DATE AND HOUR OF DEATH <u>12-11-69</u> <u>2:40 PM</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>SOUTH BALTIMORE GENERAL HOSPITAL</u> <u>301 SHANOVER ST.</u> <u>BALTO, MD 21230</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO, CITY</u> <u>2402</u> C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>750 E. FORT AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-2-03</u>	9. AGE (In years last birthday) <u>66</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAMAN</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>WILLIAM T. Turbeville Sr.</u>			
14. MOTHER'S MAIDEN NAME <u>EMMIE CARAWAY</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>CHART</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>492X1 E887</u> <u>Cardio-respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Right pneumothorax</u> <u>Chronic emphysema</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Fracture, right femur</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>19 days</u> <u>19 days</u> <u>several years</u> <u>47 days</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>10/25/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fracture femur (skeletal traction with K-wire)</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Church</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>William St & Fort Ave.</u>			
21D. TIME OF INJURY (Approx.) <u>10 24 69 UNK</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell to floor</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>10-24</u> 19 <u>69</u> to <u>12-11</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12-11</u> 19 <u>69</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Rodolfo Quiron md</u>				23B. DATE SIGNED <u>12/11/69</u>		23C. PHYSICIAN'S NAME (Type) <u>Rodolfo Quiron M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-15-69</u>		24C. NAME of CEMETERY or CREMATORY <u>Cedar Hill Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore - Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>John E. Kelly, MD</u>		25C. FUNERAL DIRECTOR <u>McBully Funeral Home</u>		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

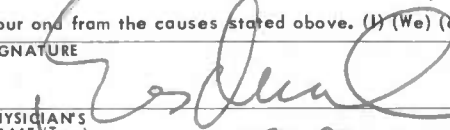
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

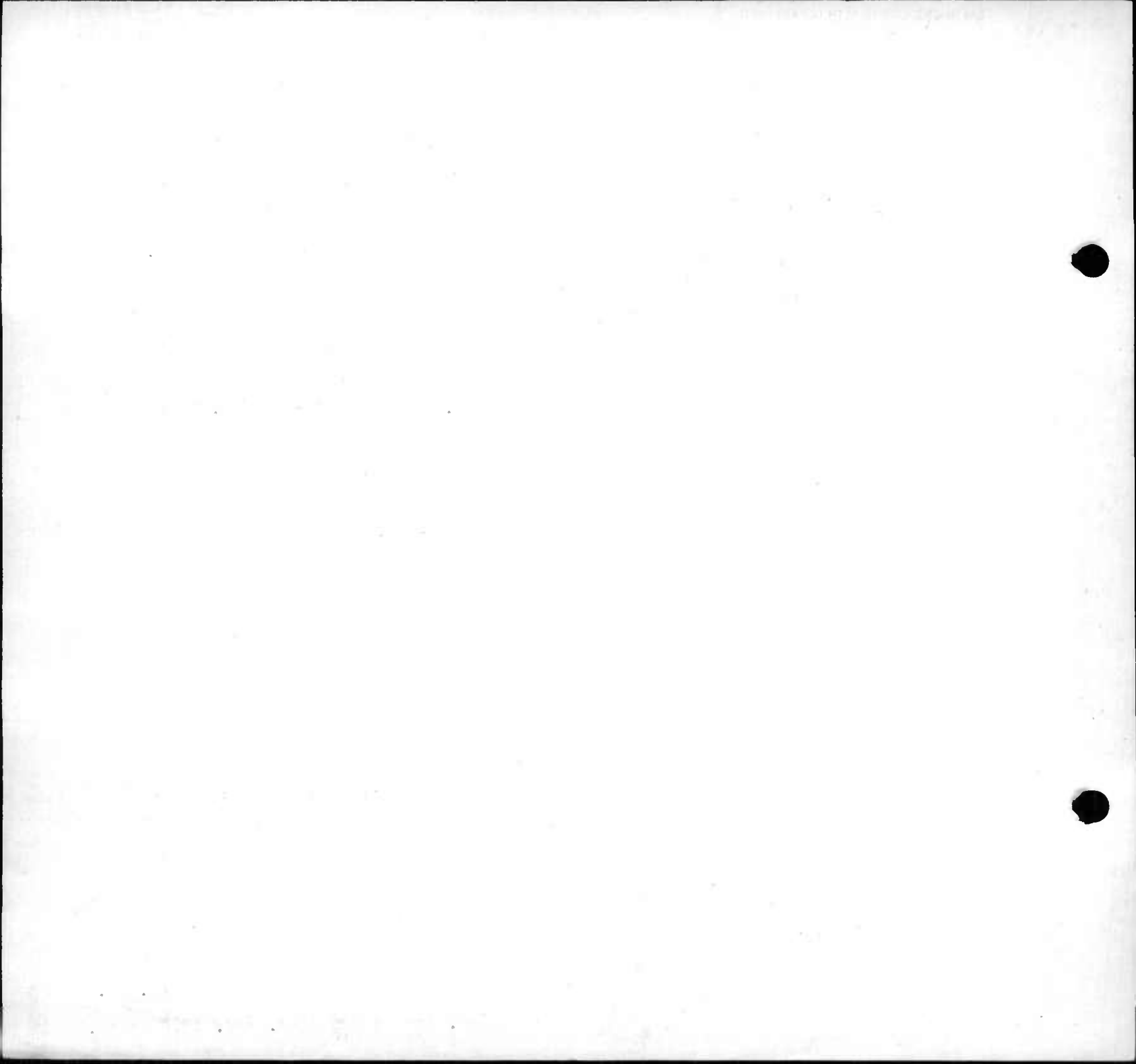
L-146		69 12310		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12310	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>LOFFLER MARIE L</u>				2. DATE AND HOUR OF DEATH <u>12/10/69</u> — <u>7:55</u> <u>AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME AND HOSPITAL</u> <u>100 N. BROADWAY</u> <u>BALTIMORE, MARYLAND 21231</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
				C. CITY OR TOWN <u>BALTIMORE, MARYLAND</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>100 N. BROADWAY</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/10/86</u>	9. AGE (In years last birthday) <u>83</u>	10. If Under 1 Yr. Months Days 11 Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>	
13. FATHER'S NAME <u>JOSEPH MERRITT</u>				14. MOTHER'S MAIDEN NAME <u>HESTER SMITH</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>218 58 6496</u>		17. INFORMANT ADDRESS	
18. <u>436.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Resp Failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>CVA</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/8/1969</u> to <u>12/10/1969</u> that (I) (we) last saw the deceased alive on <u>12/10/1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>FURZBY</u>	
				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-13-1969</u>		24C. NAME of CEMETERY or CREMATORY <u>St Paul 5th Reformed Cemt</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>WALTER DABROWSKI</u>		ADDRESS <u>1005 DUNDALK AVENUE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-425		69 12311		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12311		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GLICKMAN BESSIE				2. DATE AND HOUR OF DEATH 12-10-69 5:30 P M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 91 LEVINDALE HOME						A. STATE Maryland		B. COUNTY BALTO. CO.		
						C. CITY OR TOWN Randallstown		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
						E. STREET AND NUMBER 8501 Glen Michael Lane				
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-31-80		9. AGE (In years last birthday) 89		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Lithiania			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Abraham Michael Lampe						14. MOTHER'S MAIDEN NAME Baila Sura ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Apt 503 Mrs. Blanche Beck- 4000 N. Charles Street				
18. 412.41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PNEUMONIA (B) ASCVD. (8) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 WEEK. 20 years	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).										
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 12-9-69 19 to 12-10-69 19 that (I) (we) last saw the deceased alive on 12-9-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE 						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED		
23C. PHYSICIAN'S NAME (Type) JULIO ESQUIVEL						23D. ADDRESS Sinai Hospital				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE Dec 12 / 69		24C. NAME OF CEMETERY or CREMATORY Baltimore Hebrew		24D. LOCATION (City, town, or county) (State) 2100 Belair Rd Balto. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			25B. NAME OF REGISTRAR Robert E. Taylor			25C. FUNERAL DIRECTOR Sol? Levinson & Bros. Inc. 6010 Reist. Road				



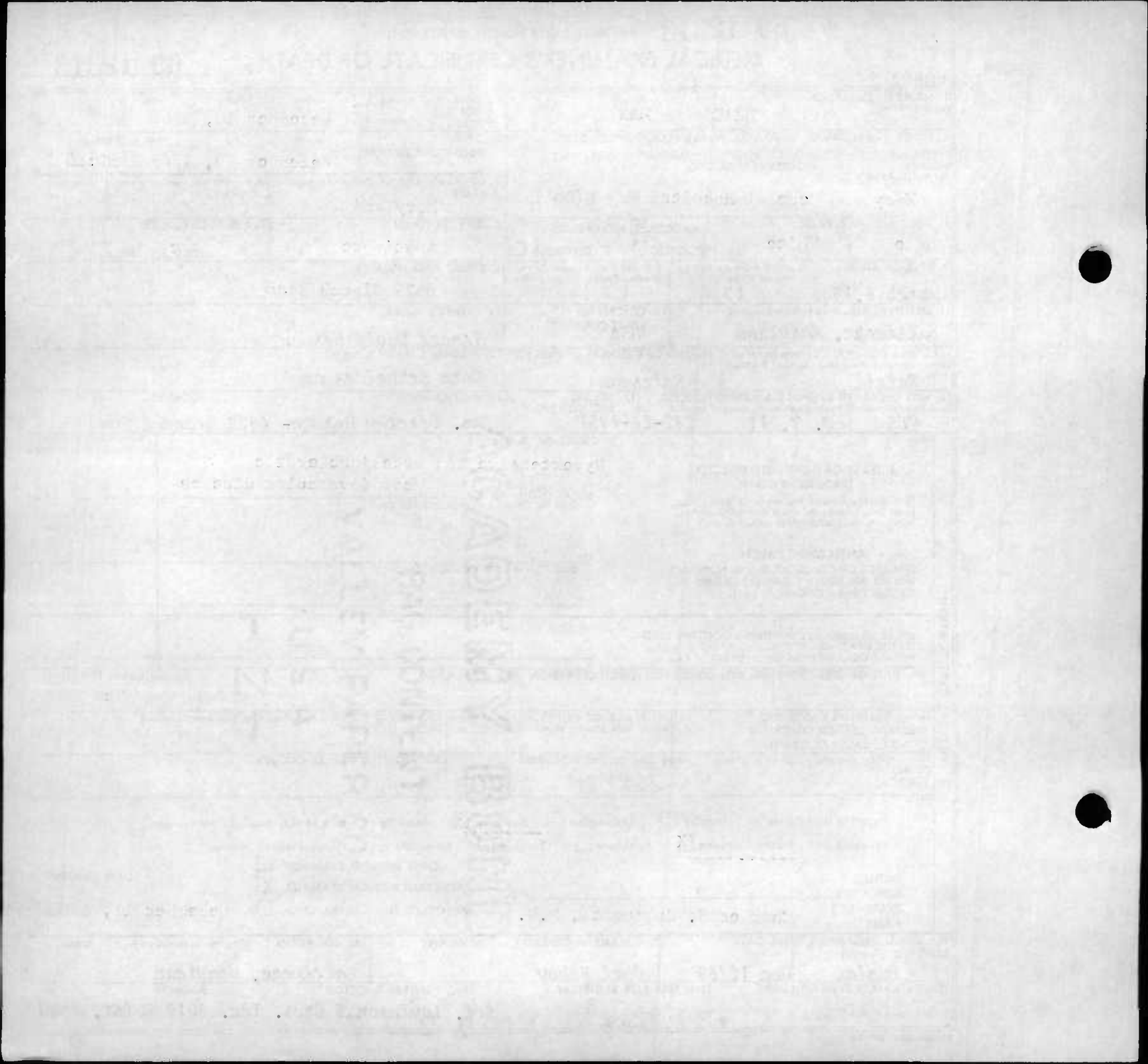
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. [REDACTED]
M-460		69 12312		69 12312
BIRTH NO.		1. NAME OF DECEASED (Type or Print) MILLER MILTON		
2. DATE AND HOUR OF DEATH 12-11-69 7:10 A.M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTIMORE 42		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE 5300		
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Technologist		E. STREET AND NUMBER 8512 Charleton Road.		
10B. KIND OF BUSINESS OR INDUSTRY Laboratory		8. DATE OF BIRTH 3-19-30 9. AGE (in years last birthday) 39		
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Late Isaac Miller		14. MOTHER'S MAIDEN NAME Ida ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean War 216-28-0807		16. SOCIAL SECURITY NO. 216-28-0807		
17. INFORMANT Mrs. Vivian Miller		ADDRESS SINAI HOSPITAL 8512 Charleton Rd		
18. CAUSE OF DEATH I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). A. IMMEDIATE CAUSE Aspiration; DUE TO, OR AS A CONSEQUENCE OF: B. Chronic Uremia; DUE TO, OR AS A CONSEQUENCE OF: C. Ileitis with Bleeding. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION 01/11/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Regional ileitis & bleeding		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 11/11/69 to 12/11/69 that (I) (we) last saw the deceased alive on 12/11/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE [Signature]		23B. DATE SIGNED 12/11/69		
23C. PHYSICIAN'S NAME (Type) DR. SAGBE K. IKIRIKO		23D. ADDRESS SINAI HOSPITAL OF BALTIMORE INC.		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 12/69		24C. NAME OF CEMETERY or CREMATORY Posvohler Friendly Society
24D. LOCATION Baltimore, Maryland		24E. STATE (State)		
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Sol. Levenson & Bros. Inc. 6010 Rettersstown Rd

~~SECRET~~

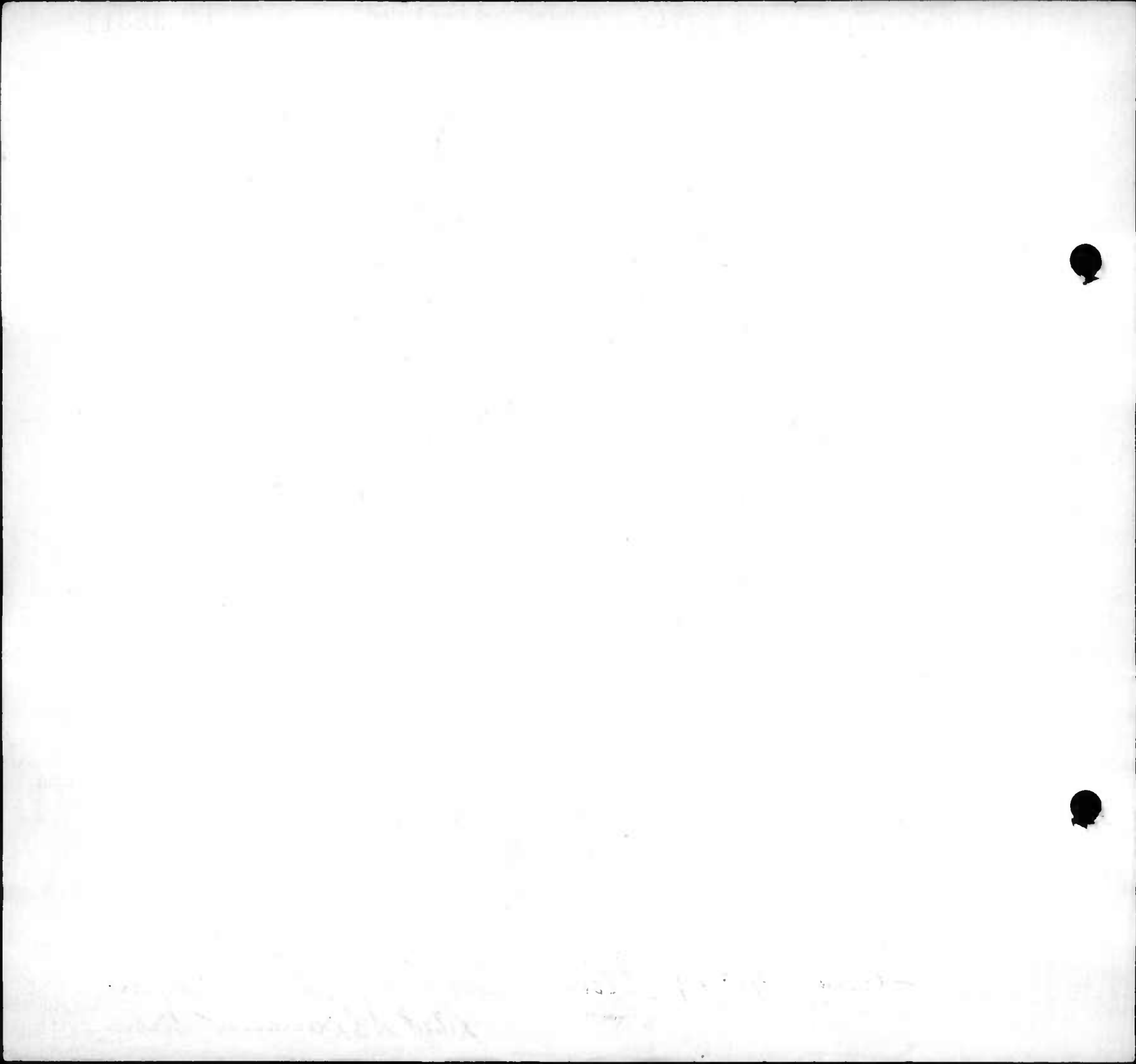
1		69 12313		BALTIMORE CITY HEALTH DEPARTMENT		X		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 69 12313	
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) MORRIS HERMAN						2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year December 10, 1969			Hour M.		
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hospital (DOA)						3. DATE PRONOUNCED DEAD Month Day Year December 10, 1969			Hour M. 12:15 P.		
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore CO. 5300						C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
6. SEX Male		7. RACE White		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 6929 Blanche Road					
9. DATE OF BIRTH March 6, 1906		10. AGE (In years last birthday) 63		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Israel David Herman		
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retail				14B. KIND OF BUSINESS OR INDUSTRY Salesman		15. MOTHER'S MAIDEN NAME Dora Schneiderman					
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES W. W. 11				17. SOCIAL SECURITY NO. 212-26-1951		18. INFORMANT ADDRESS Mrs. Dorothy Herman- 6929 Blanche Road					
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) Yes											
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED December 11, 1969 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 12/69		24C. NAME of CEMETERY or CREMATORY Ohel Yakov		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Jackson		25C. FUNERAL DIRECTOR Sol. Levinson & Bros. Inc.		ADDRESS 6010 Reist, Road					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-251		69 12314		BALTIMORE CITY HEALTH DEPARTMENT		69 12314	
BIRTH NO.				CERTIFICATE OF DEATH X Registered No.			
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <u>PAUL H. WOCKENFUSS</u>				2. DATE AND HOUR OF DEATH <u>12-9-69</u> <u>2 40</u> AM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>48 MARYLAND GEN. Hosp</u>				A. STATE <u>MD.</u> B. COUNTY <u>AN CO.</u>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>SEVERNA PARK</u>			
				D. STREET ADDRESS (If rural, give location) <u>Route 2 Box 527</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-27-11</u>	9. AGE (In years last birthday) <u>57</u>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>GREENSPRING DAIRY</u>		11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>PAUL F. WOCKENFUSS</u>				14. MOTHER'S MAIDEN NAME <u>HEADRICK WINROSKY</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>7</u>				16. SOCIAL SECURITY NO. <u>054-09-0276</u>		17. INFORMANT <u>PATIENT</u>	
				ADDRESS			
18. <u>571.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>HEPATIC INSUFFICIENCY (CARCINOMA) CAENNEC'S</u>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO			
				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>12-9-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>MASS IN ABDOMEN</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11-22</u> 19 <u>69</u> to <u>12-9</u> 19 <u>69</u> , that (we) last saw the deceased alive on <u>12-9</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Gary L. Noser</u>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12-9-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>GARY L. NOSER</u>				23D. ADDRESS <u>Maryland Gen'l Hosp</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/13/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Glen Haven</u>		24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Tabor</u>		25C. FUNERAL DIRECTOR <u>Robert E. Tabor</u>		ADDRESS <u>Severna Park Md</u>	



69 12315 CERTIFICATE OF DEATH

REG. NO.

69 12315

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Mary M. Brehm

2. DATE AND HOUR OF DEATH

12-10-1969

2.30

P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

Baltimore

2636

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

6521 Colgate Avenue

21222

5. SEX

Female

6. RACE

White

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

11-19-1885

9. AGE (In years
last birthday)

84

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

At home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John Buchhold

14. MOTHER'S MAIDEN NAME

Catherine Bock

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

217-54-2309

17. INFORMANT

Records: BCH-4940 Eastern Avenue 21224

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 10:00 AM 10 Dec 1969 to 19
that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

*Jol J. Burton MD*Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

11 Dec 69

23C. PHYSICIAN'S
NAME (Type)

JOL J. BURTON

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md.
Baltimore City Hospitals24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/13/69

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, Jr.

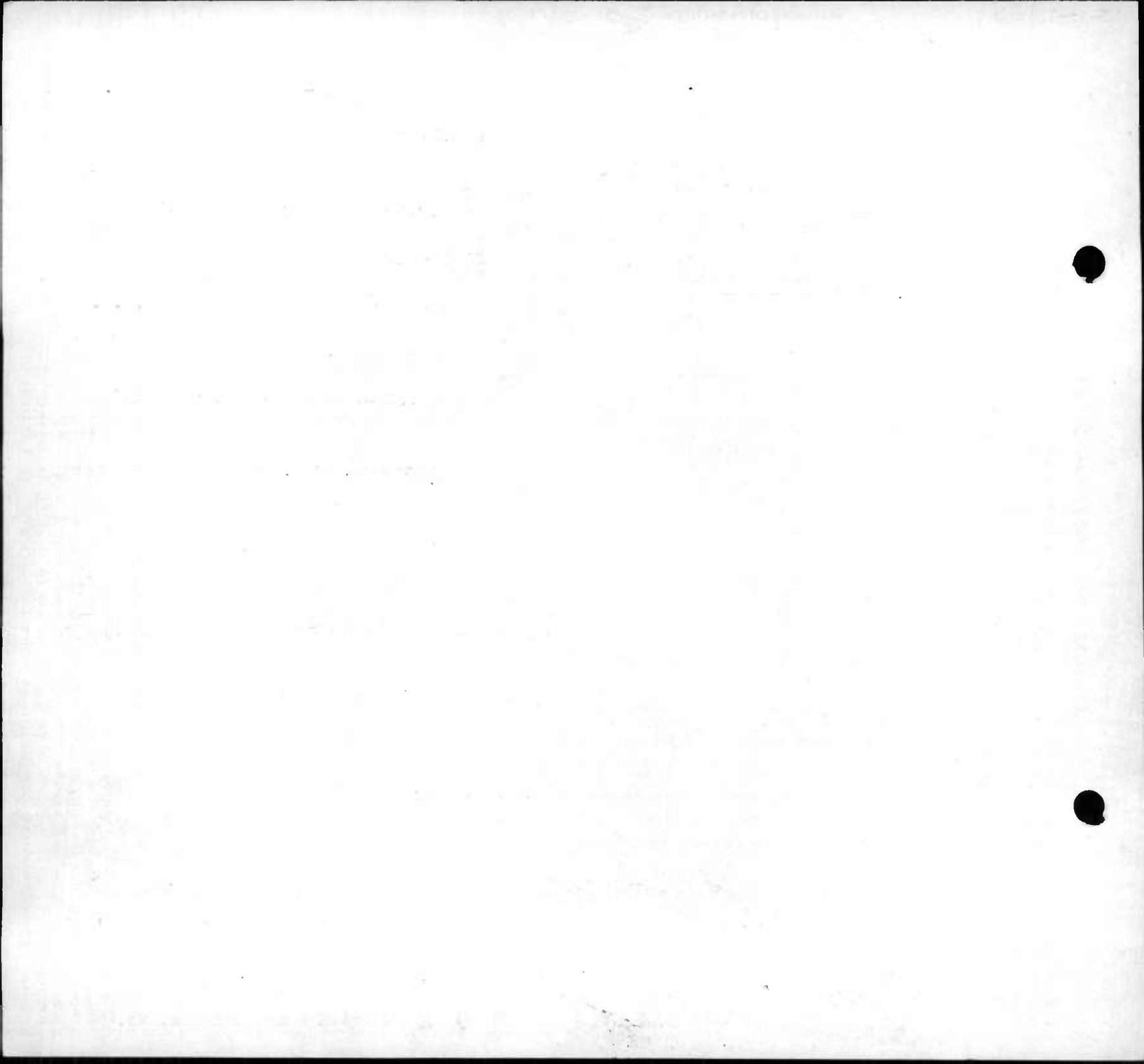
25C. FUNERAL DIRECTOR

Glrich Funeral Home, Dundalk, Md.

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12316

BIRTH NO.

1. NAME OF DECEASED (Type or Print) OTTO HAUG				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Day 12 Year 69 Hour 12:00 PM. Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1338 Hollins St.				3. DATE PRONOUNCED DEAD Month 12 Day 12 Year 1969 Hour 12:00 PM.			
6. SEX Male				7. RACE White		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 6/26/1904				10. AGE (in years last birthday) 65		11. BIRTHPLACE (State or foreign country) Baltimore Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Jacob Haug		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman	
15. KIND OF BUSINESS OR INDUSTRY Patapsco R.R.				16. MOTHER'S MAIDEN NAME Frederica ?		17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes	
18. SOCIAL SECURITY NO.				19. INFORMANT Mr Henry Haug		20. ADDRESS 1249 James St.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(A) IMMEDIATE CAUSE Carcinoma of larynx DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20A. DATE OF OPERATION				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) No				22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?				23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/16/69			
24C. NAME OF CEMETERY or CREMATORY London Park Cem.				24D. LOCATION (City, town, or county) (State) Baltimore Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969				25B. NAME OF REGISTRAR Robert E. Fisher, M.D.			
25C. FUNERAL DIRECTOR John J. Gowan & Son Inc.				25D. ADDRESS 901 St. Hollins 25, Md.			

100-100

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100-100

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-420

69 12317

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 12317

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Wm. FRANK Giles, Sr.

2. DATE AND HOUR OF DEATH

12/11/69 11:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

37 MERCY Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

E. STREET AND NUMBER

3509 Old Mill Road 21207

5. SEX

Male

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

November 12, 92

9. AGE (In years
lost birthday)

77

If Under 1 Yr.
Months DaysIf Under 24 Hrs.
Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Personal Work

10B. KIND OF BUSINESS OR INDUSTRY

Franklin Balmar Corp.

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William A. Giles

14. MOTHER'S MAIDEN NAME

Frances Arden

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

212-10-9068A

17. INFORMANT

ADDRESS

Mrs. Mary Rea Giles 3509 Old Mill Road 21207

18. 412.4 - 250.9

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) ASCVD

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 days

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

① Dehydration ② Diarrhea

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that ~~the~~ (this hospital) attended the deceased from 12/16 1969 to 12-17 1969
that ~~the~~ (we) last saw the deceased alive on 12/17 1969 and that in ~~my~~ (our) opinion death occurred on the date
and hour and from the causes stated above. ~~the~~ (We) (did) (did not) view the body after death.

23A. SIGNATURE

C. E. DeFelix

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

23C. PHYSICIAN'S
NAME (Type)

C. E. DeFelix

23D. ADDRESS

DEGREE

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/13/69

24C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

24D. LOCATION

(City, town, or county)

Baltimore, Maryland

(State)

25A. DATE RECD BY HEALTH DEPT.

DEC 15 1969

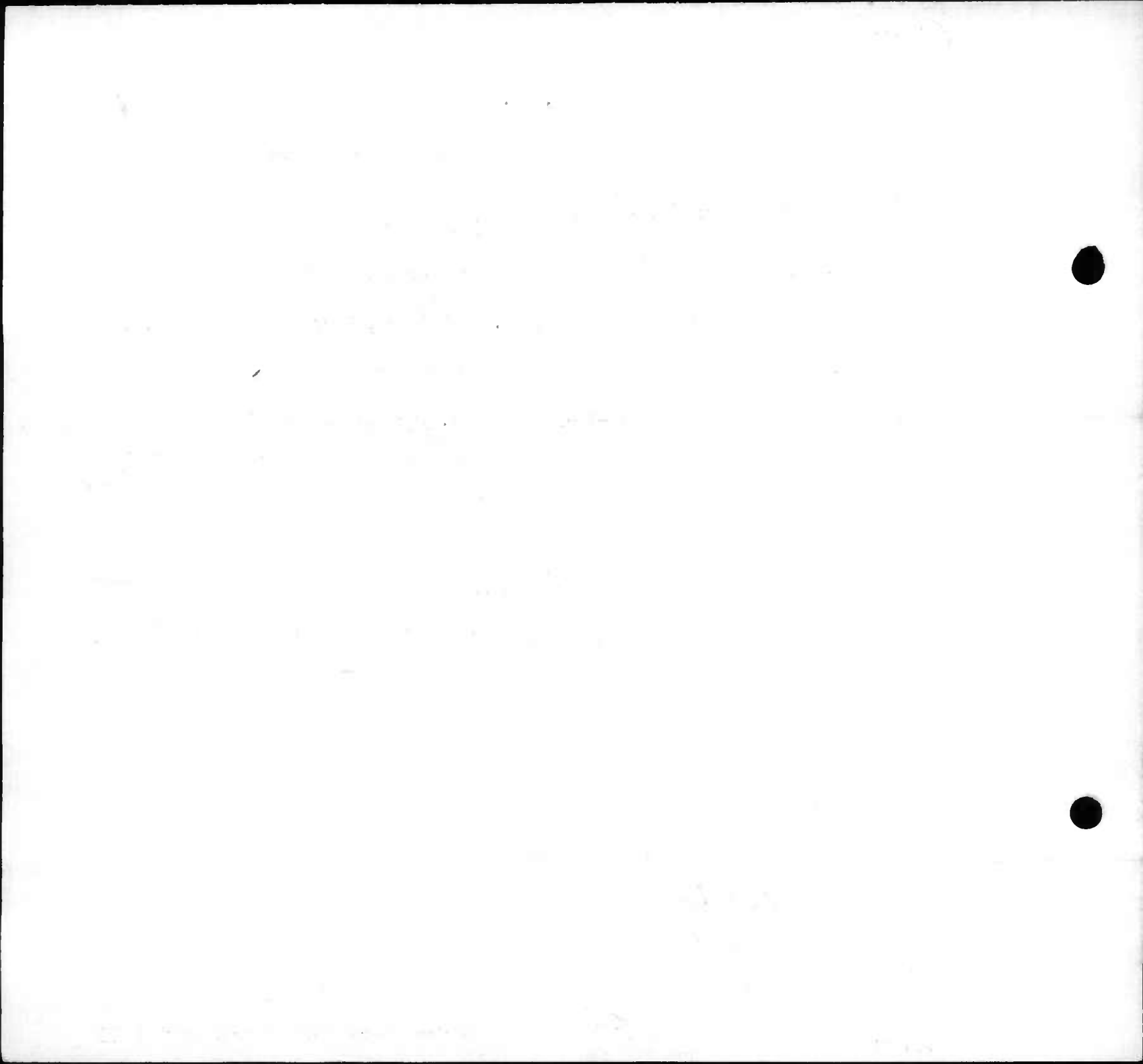
25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Loring Byers 8728 Liberty Road 21133

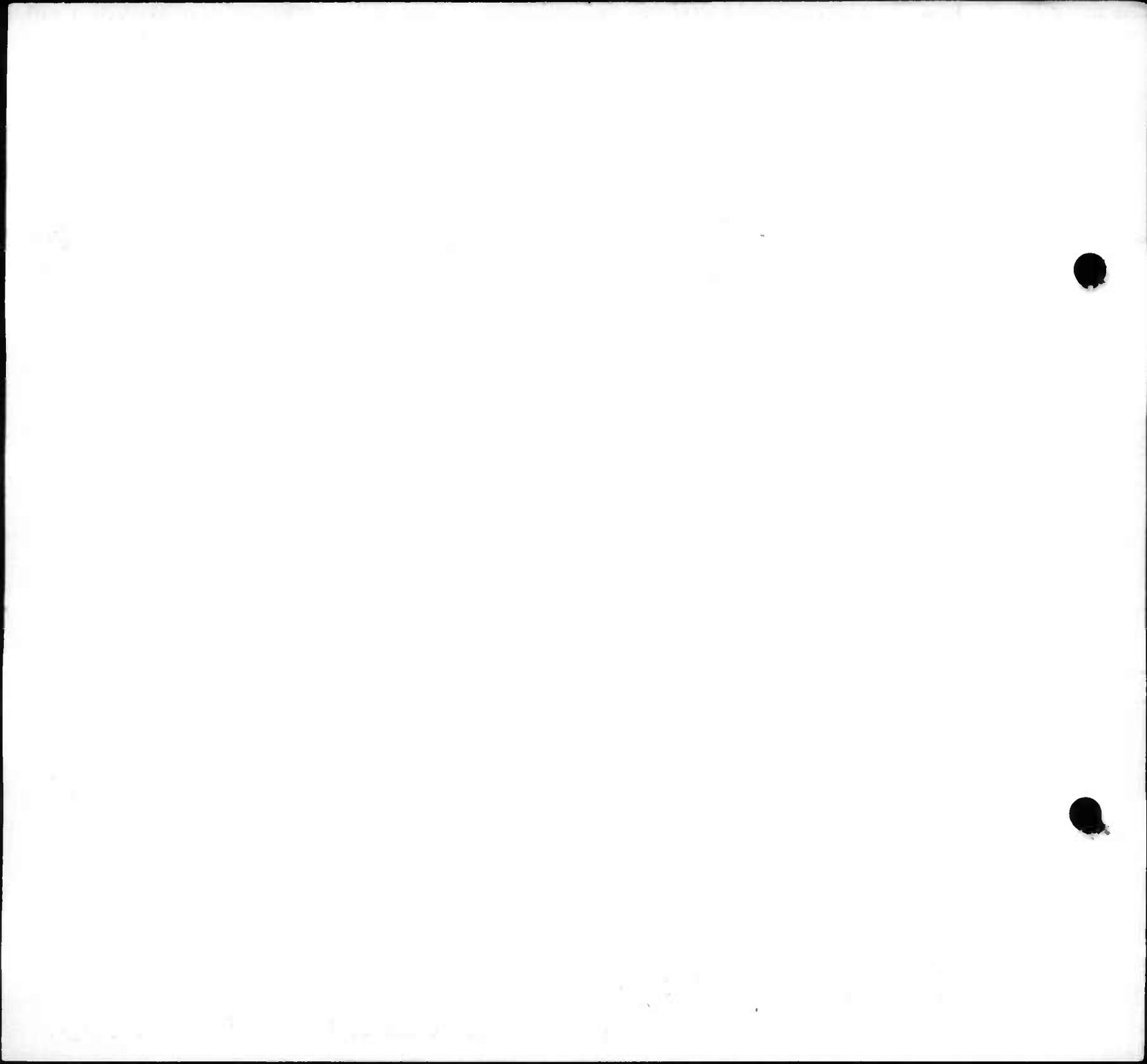
ADDRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

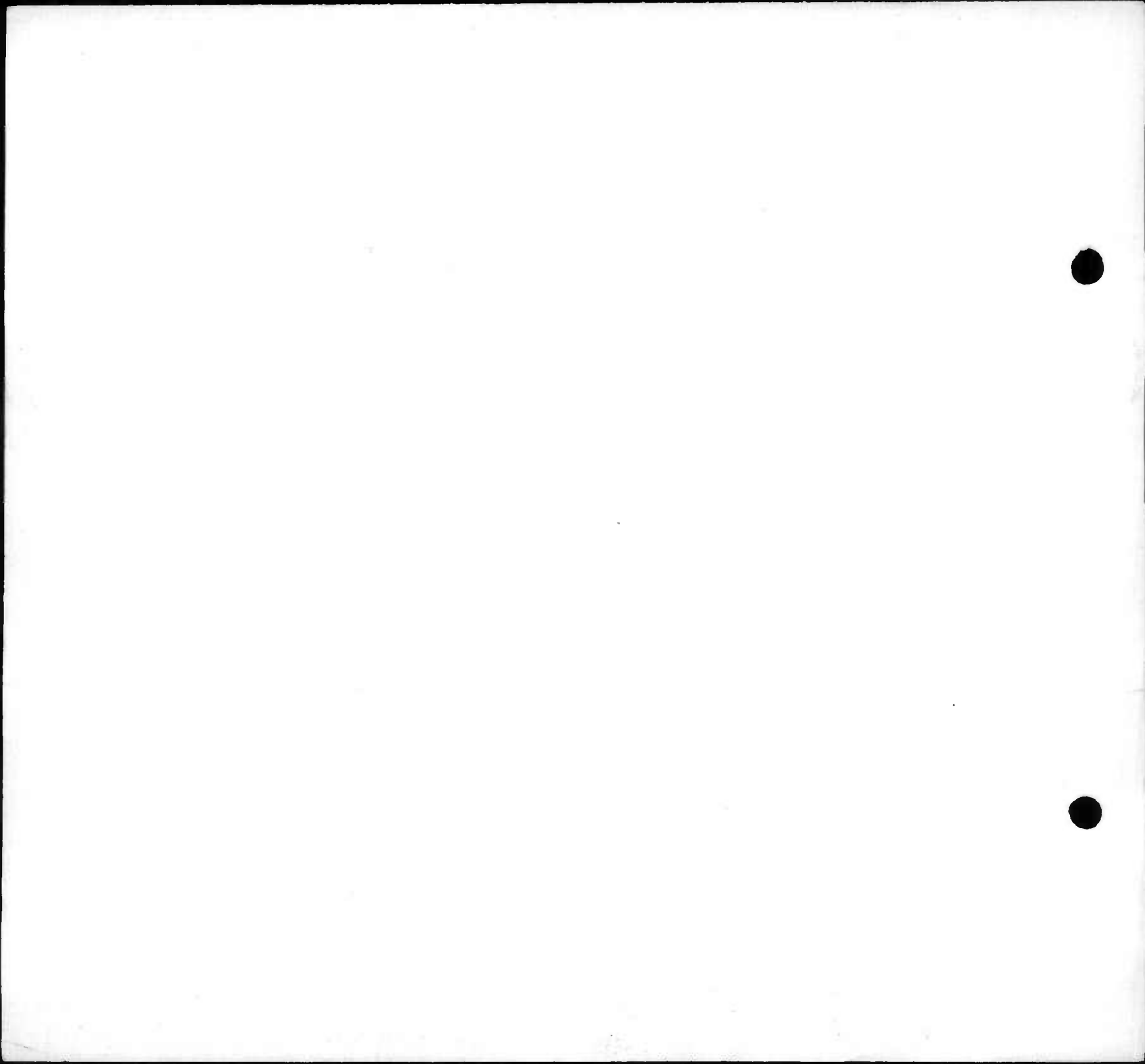
B-631		69 12318		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO.		69 12318	
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) <u>RUTH E. BROADBELT</u>						2. DATE AND HOUR OF DEATH <u>DEC. 2, 1969</u> <u>8²⁰</u> <u>P</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIVERSITY HOSPITAL -</u> <u>38 GREENE + REDWOOD ST.</u>						A. STATE <u>BALTO.</u> B. COUNTY <u>MARYLAND</u>					
						C. CITY OR TOWN <u>BALTO.</u>			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
						E. STREET AND NUMBER <u>3120 ST. PAUL ST.</u> <u>1202</u>					
5. SEX <u>F</u>		6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-29-05</u>		9. AGE (in years last birthday) <u>64</u>		10. Under 1 Yr. 11. Under 24 Hrs. 12. Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RADIO THERAPIST</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>DEPT. OF RADIO THERAPY</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>HENRY ALBERT BROADBELT</u>						14. MOTHER'S MAIDEN NAME <u>BERTIE MALAMBRE</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-36-2875</u>		17. INFORMANT				ADDRESS	
18. <u>410.9 I</u> CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(A) IMMEDIATE CAUSE <u>PULMONARY EMBOLUS</u> DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>		
						(B) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF:			<u>1 wk.</u>		
						(C) <u>CONGESTIVE HEART FAILURE</u>			<u>1 wk.</u>		
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>None</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>None</u>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>11/28/69</u> <u>19 69</u> to <u>12/2</u> <u>1969</u> that (I) (we) last saw the deceased alive on <u>12/2</u> <u>19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Marquerite J. Moran M.D.</u>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>Dec. 2, 1969</u>		
23C. PHYSICIAN'S NAME (Type) <u>Marquerite J. Moran</u>						23D. ADDRESS <u>University Hospital, Balto. Maryland.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12-8-69</u>		24C. NAME of CEMETERY or CREMATORY <u>WOODLAWN</u>				24D. LOCATION (City, town, or county) (State) <u>WOODLAWN MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>				25B. NAME OF REGISTRAR <u>Robert E. Ticker</u>				25C. FUNERAL DIRECTOR ADDRESS <u>TICKNER, F.H. BALTO. MD.</u>			



FUNERAL DIRECTOR: IMPORTANT

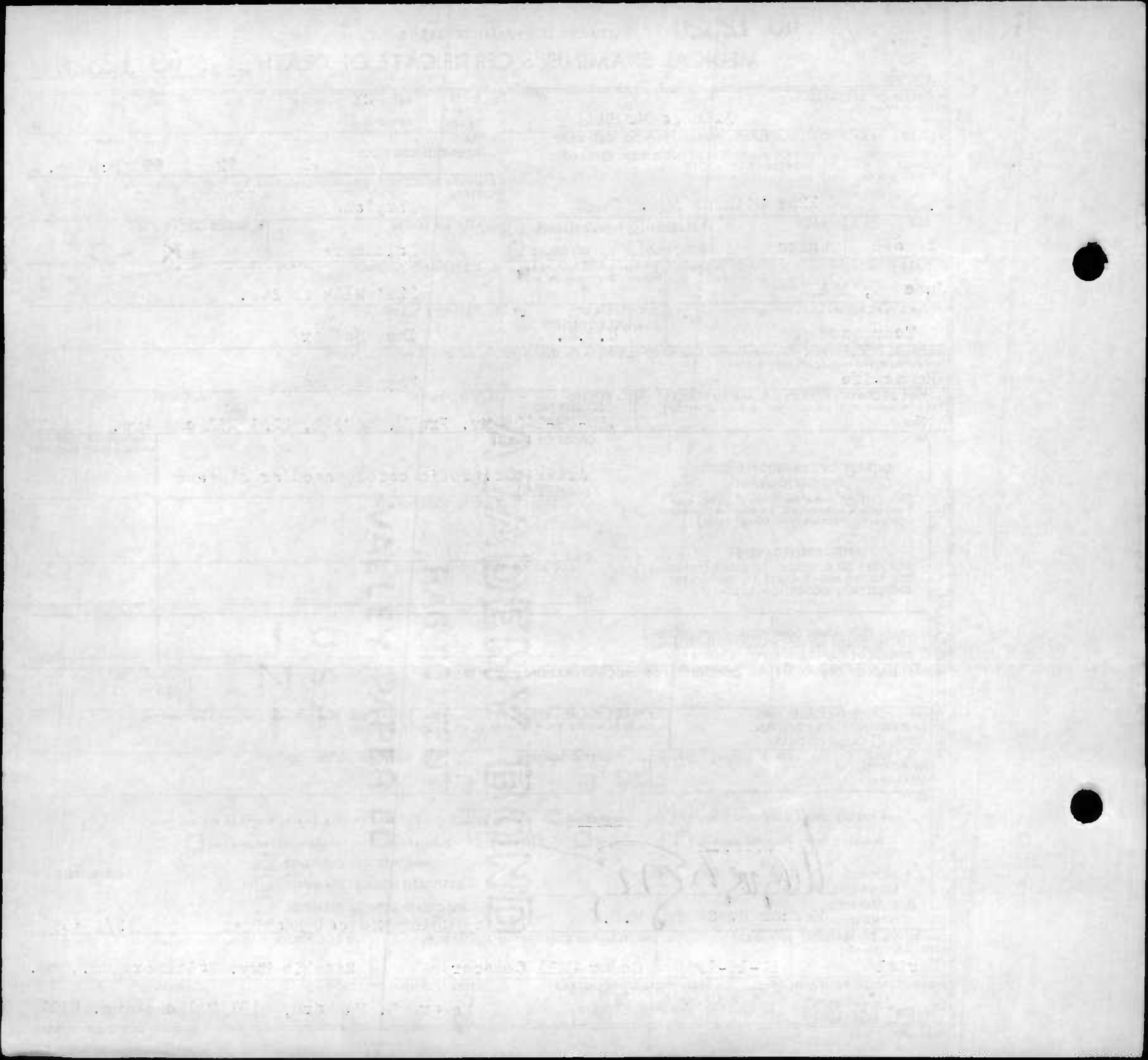
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-435		69 12319		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12319	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
		Gildner, Dorothy				11-29-69 11:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						A. STATE B. COUNTY			
Maryland General Hospital						Ohio, Dayton V-32			
C. CITY OR TOWN						D. INSIDE CITY LIMITS?			
Dayton						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER						F. STREET AND NUMBER			
515 W. Bahn Road						515 W. Bahn Road			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
F		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8-28-22		47	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)						10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
housewife						—		Georgia	
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME			
Ernest P. Johnson						Williamson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT	
						352-28-5097		husband admission sheet	
18. 223.01 CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH						(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						Internal hydrocephalus			
ANTECEDENT CAUSES						DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) Large Port for Meningioma			
						(C) —			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/2/69 19 69 to 11/29 19 69 that (I) (we) last saw the deceased alive on 11/29 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE						23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
M. F. Whitworth M.D.						11/29/69		M. F. WHITWORTH M.D.	
23D. ADDRESS						23E. FUNERAL DIRECTOR			
MD. GENERAL HOSP.						Wm. F. Fickner & Son North & Penn Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT.	
Burial		12-4-69		Dayton, Ohio		Dayton, Ohio		DEC 15 1969	
25B. NAME OF REGISTRAR		25C. NAME OF REGISTRAR		25D. NAME OF REGISTRAR		25E. NAME OF REGISTRAR		25F. NAME OF REGISTRAR	



M-240 69 12320 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. **69 12320**

BIRTH NO.		1. NAME OF DECEASED (Type or Print) Arizona McGill		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 2251 Wilkens Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 12 69 5:08 p. M.		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY 2005	
6. SEX female	7. RACE white	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH June 6, 1913		10. AGE (In years last birthday) 56	11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF U.S.A.
13. FATHER'S NAME Ike Seiber		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Maggie Bunch	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 410-09-2426		18. INFORMANT Mr. Ira K. McGill, 2251 Wilkens Ave., 21223	
19. CAUSE OF DEATH 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ii OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner <input type="checkbox"/> DATE SIGNED 12/13/69					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-16-1969		24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Ritchie Hwy. Baltimore Co., Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS			



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K-400

69 12321 BALTIMORE CITY HEALTH DEPARTMENT

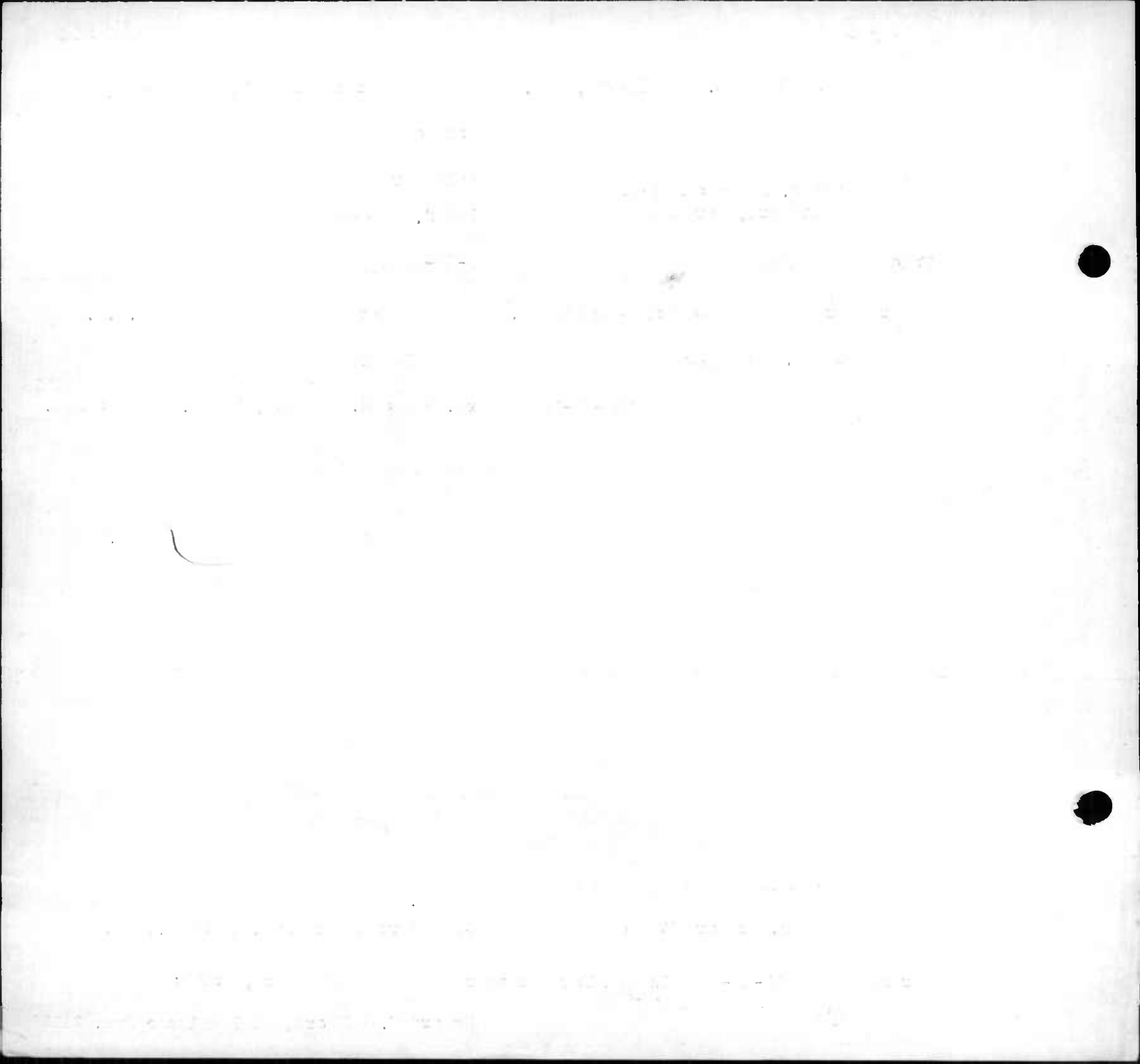
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12321

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CALVIN C. KEIL, SR.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month December Day 11 Year 1969 Hour 9:45 A. M. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month December Day 11 Year 1969 Hour 9:45 A. M. M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2551	
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 11-22-1922		10. AGE (In years last birthday) 47		E. STREET AND NUMBER 4023 Wilkens Avenue	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William F. Keil	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lt. Fireman		14B. KIND OF BUSINESS OR INDUSTRY Balto. City Fire Dept		15. MOTHER'S MAIDEN NAME Lena Selma Schlutter	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes Korean		17. SOCIAL SECURITY NO. 217-16-8053		18. INFORMANT ADDRESS Mr. Melvin D. Keil, 3919 Wilkens Ave. 21229	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Charles S. Springate, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED December 11, 1969 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-1969		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229			

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. S-140		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12322	
1. NAME OF DECEASED (Type or Print) JOHN E. SHIPLEY, SR.			2. DATE AND HOUR OF DEATH December 12, 1969 5:15 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 203 S. Augusta Avenue Baltimore, Maryland			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2008 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 203 S. Augusta Avenue		
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-17-1901	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Eastern Overall Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James E. Shipley			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-07-2546		17. INFORMANT ADDRESS Mrs. Hilda E. Shipley, 203 S. Augusta Ave. 21229	
18. 410.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) Arteriosclerotic - Arterio-sclerotic CVD (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 minute 12 years		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept 30 19 44 to Dec 13 19 69 , that (I) (we) last saw the deceased alive on Nov. 15 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kennard Yaffe MD				23B. DATE SIGNED 12/13/69	
23C. PHYSICIAN'S NAME (Type) Dr. Kennard Yaffe				23D. ADDRESS 5501 Forest Park Ave., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-16-69		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			
25B. FUNERAL DIRECTOR Howard H. Hubbard		25C. ADDRESS 4107 Wilkens Ave. 21229			



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A-423

69 12323

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12323

BIRTH NO.

1. NAME OF DECEASED (Type or Print) EVELYN E. ALSID		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> December 5, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Mercy Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 5, 1969 5:10 P. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN PARKVILLE	
9. DATE OF BIRTH June 16, 1918		10. AGE (In years last birthday) 51	
11. BIRTHPLACE (State or foreign country) NEBRASKA		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SEC. Y		14B. KIND OF BUSINESS OR INDUSTRY VET. ADMINISTRATION	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 508-05-9917	
18. INFORMANT PAUL ALSID		ADDRESS SAME	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-6-69			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-9-69	
24C. NAME of CEMETERY or CREMATORY MORELAND MEMORIAL		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR C. E. EVANS & SON		ADDRESS 8802 HARFORD RD.	

ADDITIONAL INFORMATION

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S-000 69 12324

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12324

BIRTH NO.

1. NAME OF DECEASED (Type or Print) NARESH SHAH

2. DATE OF DEATH Known ☒ Estimated ☐ Month 12 Day 5 Year 69 Hour 2:22 a.m.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Johns Hopkins Hospital D.O.A.

3. DATE PRONOUNCED DEAD Month December 5, 1969 Year 2:22 a.m.

5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY Harrisburg Pa V-35

6. SEX Male 7. RACE Indian 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN Harrisburg D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH Feb. 2, 1944 10. AGE (in years last birthday) 25 If Under 1 Yr. if Under 24 Hrs. Months Days Hours Min.

11. BIRTHPLACE (State or foreign country) India 12. CITIZEN OF WHAT COUNTRY? India 13. FATHER'S NAME Vimalbhai Balabhai Shah

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 14B. KIND OF BUSINESS OR INDUSTRY Design 15. MOTHER'S MAIDEN NAME Uimalbhai Shah

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No 17. SOCIAL SECURITY NO. 222 36 7155 18. INFORMANT ADDRESS Navin N. Patel 6651 Wycombe Way 21234

19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

(A) IMMEDIATE CAUSE Craniocerebral injuries DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21. AUTOPSY? (Yes or No) YES

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Rt. 40 near Rosedale 5300

22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12 5 69 1:28a 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 22F. HOW DID INJURY OCCUR? Subject passenger in auto-fixed object coll.

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Tsidore Mihalakis, M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED 12/5/69

24A. BURIAL CREMATION, REMOVAL (Specify) Cremation 24B. DATE 12-9-69 24C. NAME OF CEMETERY or CREMATORY Green Mount Crematory 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969 25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR ADDRESS William E. Johnson 8521 Loch Raven Blvd.

ACADEMY (101111)

[Handwritten signature]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12325

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BHART G. TRIVEDI (TRIVEDI)				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Day 5 Year 69 Hour 3:38 a.m. Estimated <input type="checkbox"/>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 City Hospital				3. DATE PRONOUNCED DEAD Month December Day 5 Year 1969 Hour 3:38 a.m.			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE PA. B. COUNTY V-35			
6. SEX Male	7. RACE Indian	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Harrisburg		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH May 3, 1945		10. AGE (In years last birthday) 24		11. BIRTHPLACE (State or foreign country) India		12. CITIZEN OF WHAT COUNTRY? India	
13. FATHER'S NAME Gunvantbhai Ratilal Trivedi		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		15. MOTHER'S MAIDEN NAME Urmilabeh Gunvantbhai Trivedi		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. 222 38 5060		18. INFORMANT Navin N. Patel		19. CAUSE OF DEATH ES/ISTO DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Multiple injuries ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) YES	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? U.S. Rte. 40 9' E. of Odell Ave.			
22D. TIME OF INJURY (APPROX.) 12 5 69 1:28 a		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject driver in auto-fixed object coll			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Isidore Mihalakis, M.D. M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/5/69							
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12-9-69		24C. NAME OF CEMETERY or CREMATORY Green Mount Crematory		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR John E. Johnson		25C. FUNERAL DIRECTOR ADDRESS William E. Johnson 8521 Loch Raven Blvd.			

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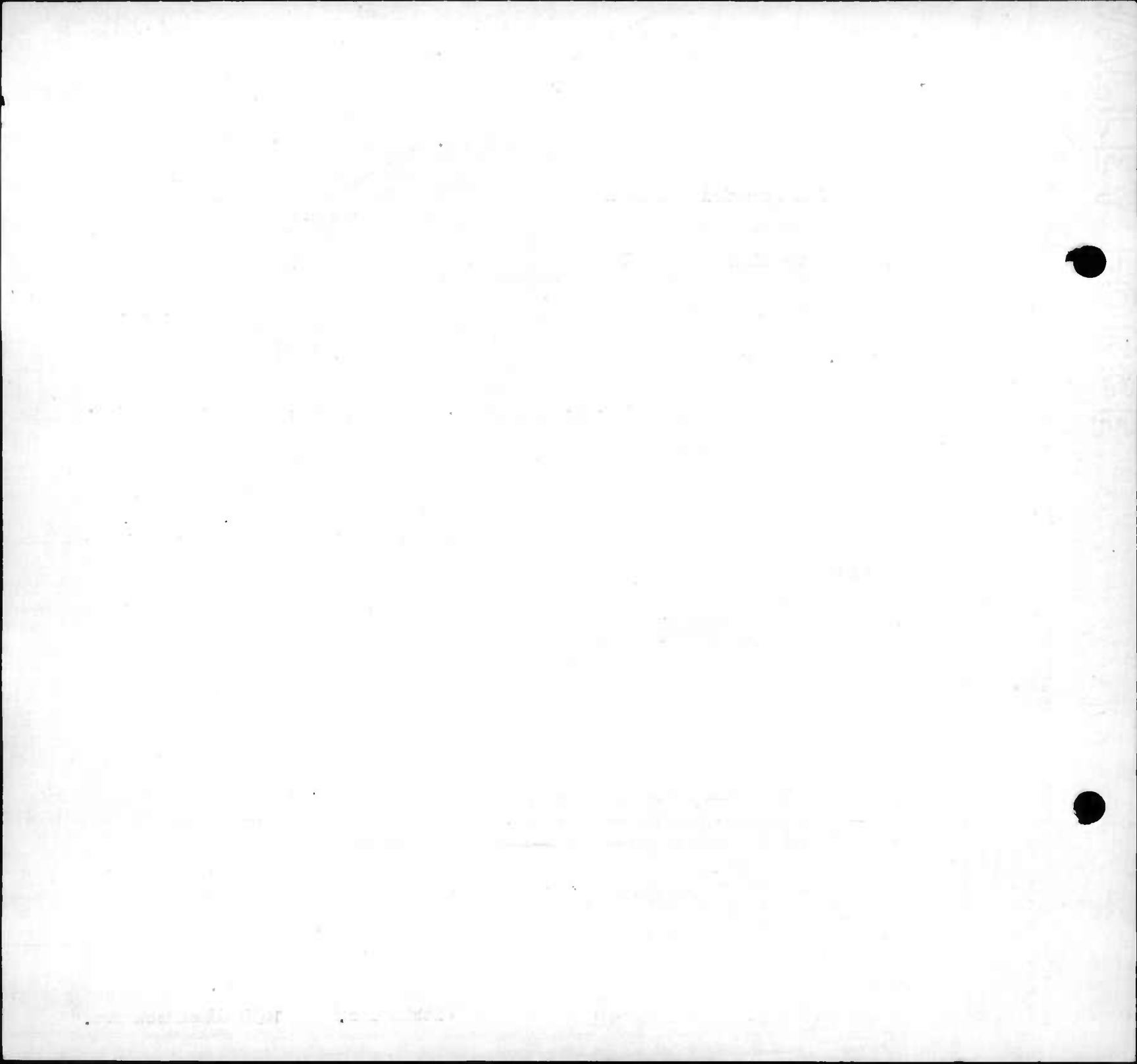
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O.K. by Coroner's office.
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

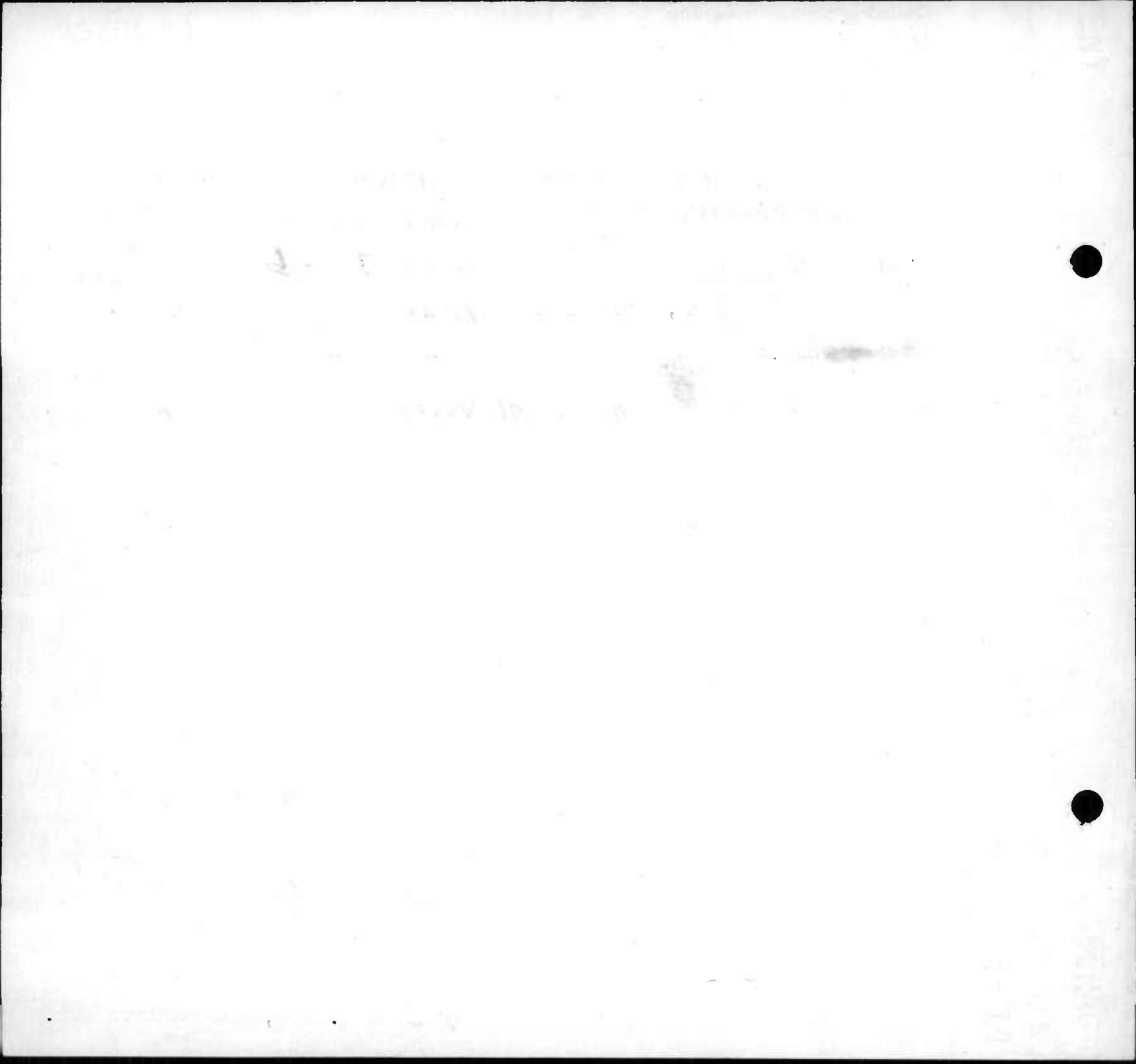
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12326
B-600 69 12326 CERTIFICATE OF DEATH		BIRTH NO. 69 12326		
1. NAME OF DECEASED (Type or Print) Hilda Beyer		2. DATE AND HOUR OF DEATH 12/11/69 6:25P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2551 2551 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3646 Coolidge Ave		
5. SEX Female	6. RACE Caucasian	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/1900	9. AGE (In years last birthday) 69 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Frank C. Delcher		14. MOTHER'S MAIDEN NAME Katherine Nelson		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-34-9236A		17. INFORMANT Mrs. Harold Ammons, 3646 Coolidge Ave. ADDRESS
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/10/91 Coronary thrombosis		CAUSE OF DEATH 2 hr. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Anteroseptal Heart Disease 2 yr. DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART (A)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in at about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (the hospital) attended the deceased from 12/11 1969 to 12/11 1969, that (I) (we) last saw the deceased alive on 12/11 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE Norman R. Freeman				23B. DATE SIGNED 12/11/69
23C. PHYSICIAN'S NAME (Type) NORMAN R. FREEMAN JR MD				23D. ADDRESS 11 W 29th ST.
24A. BURIAL CREMATION Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery
24D. LOCATION (City, town, or county) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Witke Inc.		
25D. ADDRESS		1630 Edmondson Ave. Catonsville		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

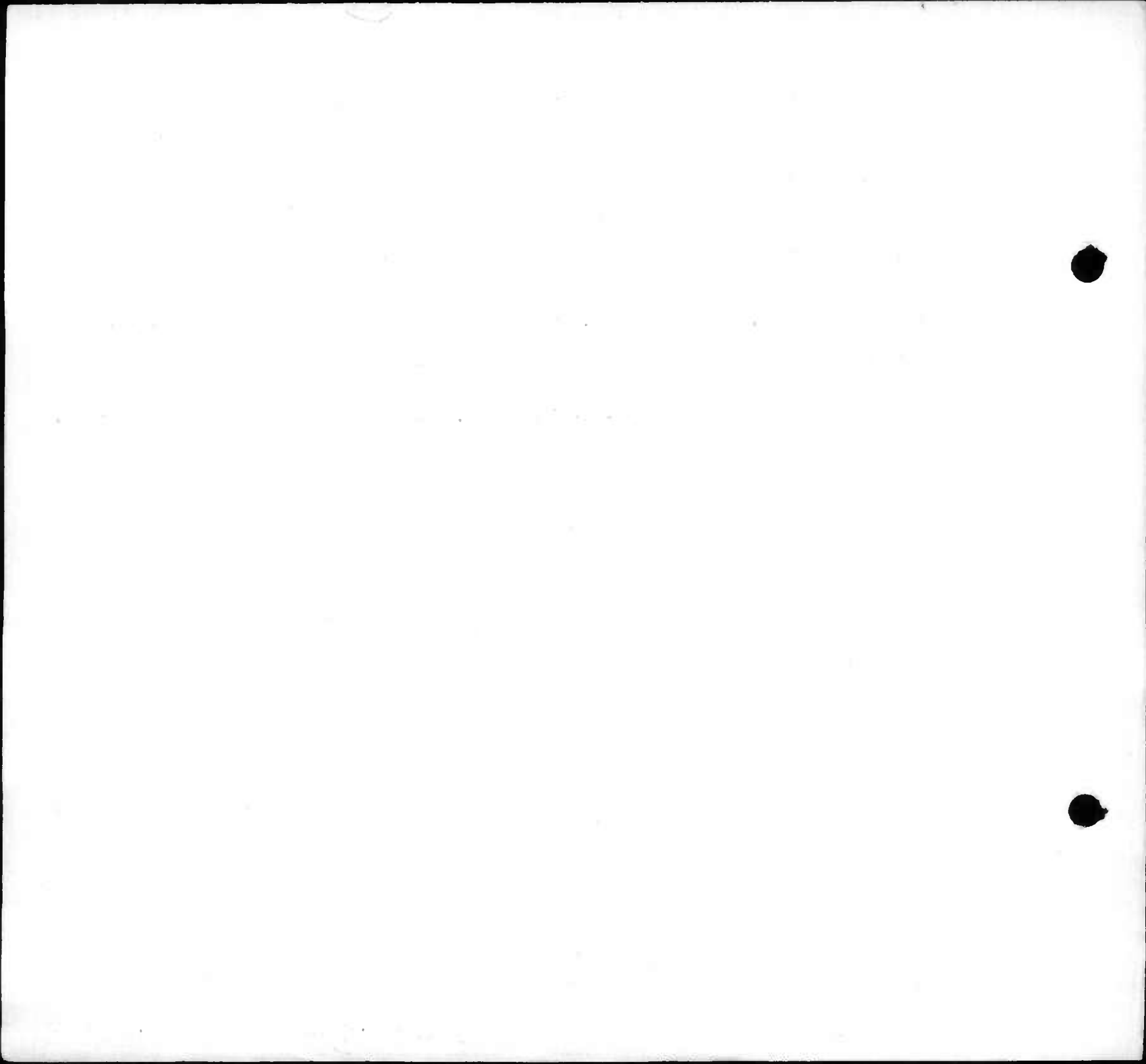
D-251		69 12327		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12327	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>DUSEN BERRY, LEONARD</u>			
2. DATE AND HOUR OF DEATH <u>12-11-69</u> <u>4 A</u> M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF MARYLAND</u> <u>46 730 ASHBURTON STREET</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>1701</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>800 MADISON AVE.</u>			
5. SEX <u>MALE</u>	6. RACE <u>N.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-22-03</u>	9. AGE (In years last birth day) <u>66</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Door Checker, Enoc Pratt</u>		11. BIRTHPLACE (State or foreign country) <u>MASS.</u>
13. FATHER'S NAME <u>peter Dusenberry</u>				14. MOTHER'S MAIDEN NAME <u>Lidia Foulks</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WWI Navy</u>				16. SOCIAL SECURITY NO. <u>117-01-2091</u>		17. INFORMANT <u>WIFE</u>	
18. <u>200.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>LYMPHOSARCOMA</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>LYMPHOSARCOMA</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10-19</u> 19 <u>69</u> to <u>12-11</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12-10</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Violeta R. Gamarral</u>				23B. DATE SIGNED <u>12/11/69</u>		23C. PHYSICIAN'S NAME (Type) <u>VIOLETA R. GAMARRAL R.M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-15-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>Phyllis R. Law</u>		25C. FUNERAL DIRECTOR <u>Phyllis R. Law</u>		ADDRESS <u>802 Madison Ave.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-352		69 12328		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12328	
BIRTH NO.				2			
1. NAME OF DECEASED (Type or Print) <u>STEINGASS, HERMAN N</u>				2. DATE AND HOUR OF DEATH <u>12/12/69</u> <u>12:50</u> P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. AGNES HOSP.</u>				A. STATE <u>MD.</u> B. COUNTY <u>BALTO.</u>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>40 Catonsville + Wilkes Ave</u>				C. CITY OR TOWN <u>BALTO.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER <u>1900 Fred. Rd.</u>							
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/23/05</u>	9. AGE (In years last birthday) <u>64</u>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired Chief Eng.</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Eastern Prod. Corp</u>			
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Ludwig Steingass</u>				14. MOTHER'S MAIDEN NAME <u>Maria</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <u>unknown</u>				16. SOCIAL SECURITY NO. <u>212-01-5933</u>			
17. INFORMANT <u>Mrs. Doretta Steingass</u>				ADDRESS <u>1900 Frederick Rd.</u>			
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <u>Cardio Respiratory Arrest</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Ventricular Fibrillation</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Acute Myocardial Infarct.</u> (C) <u>A-SCVD - Myocardial Infarct on Nov. 15/69. Discharged Dec 11/69</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> 19 <u>69</u> to <u>Dec 12</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>Dec 11</u> 19 <u>69</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Alexandro Mejia</u>				23B. DATE SIGNED <u>12-12-69</u>		23C. PHYSICIAN'S NAME (Type) <u>ALEXANDRO MEJIA</u>	
23D. ADDRESS <u>St Agnes Hospital. Catonsville</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/15/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Lorraine Mausoleum</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, Inc.</u>		ADDRESS <u>1630 Edmondson Ave., Catonsville</u>	



1

G-416

69 12329

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12329

BIRTH NO.

1. NAME OF DECEASED (Type or Print) HARRY GILBERT		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> December 10, 1969		Month December Day 10 Year 1969 Hour M.
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION St. Agnes Hospital (DOA)		3. DATE PRONOUNCED DEAD Month December Day 10 Year 1969 Hour 3:50 P.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2006
6. SEX Male	7. RACE White	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore
9. DATE OF BIRTH June 1, 1916		10. AGE (In years last birthday) 53	E. STREET AND NUMBER 3113 Stafford Street	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Gilbert
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grave Digger		14B. KIND OF BUSINESS OR INDUSTRY Cemetery		15. MOTHER'S MAIDEN NAME Auguata Gent
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 218-09-0192		18. INFORMANT Mrs. Myrtle Dodd 3027 Strickland St. Balto. Md.
19. E 955X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE Gunshot wound of head DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) Yes
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Cemetery		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 3801 Frederick Ave.-Loudon Park Cemetery
22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 12-10-69 3:30 P.m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot self
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Charles S. Springate M.D. EXAMINER'S NAME (Type) Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED December 11, 1969				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 13, 1969		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		
25B. NAME OF REGISTRAR Robert E. Seabury		25C. FUNERAL DIRECTOR G. Truman Schwab		
25D. ADDRESS 21229		25E. ADDRESS 3512 Frederick Ave. Balto. Md.		

MEDICAL EXAMINER'S REPORT

Page No.

Date

Time

Place

Case No.

Age

Sex

Occupation

History

Examination

Diagnosis

Prognosis

Treatment

Remarks

Signature

Witness

Coroner

Medical Examiner

Physician

Nurse

Pathologist

Forensic Scientist

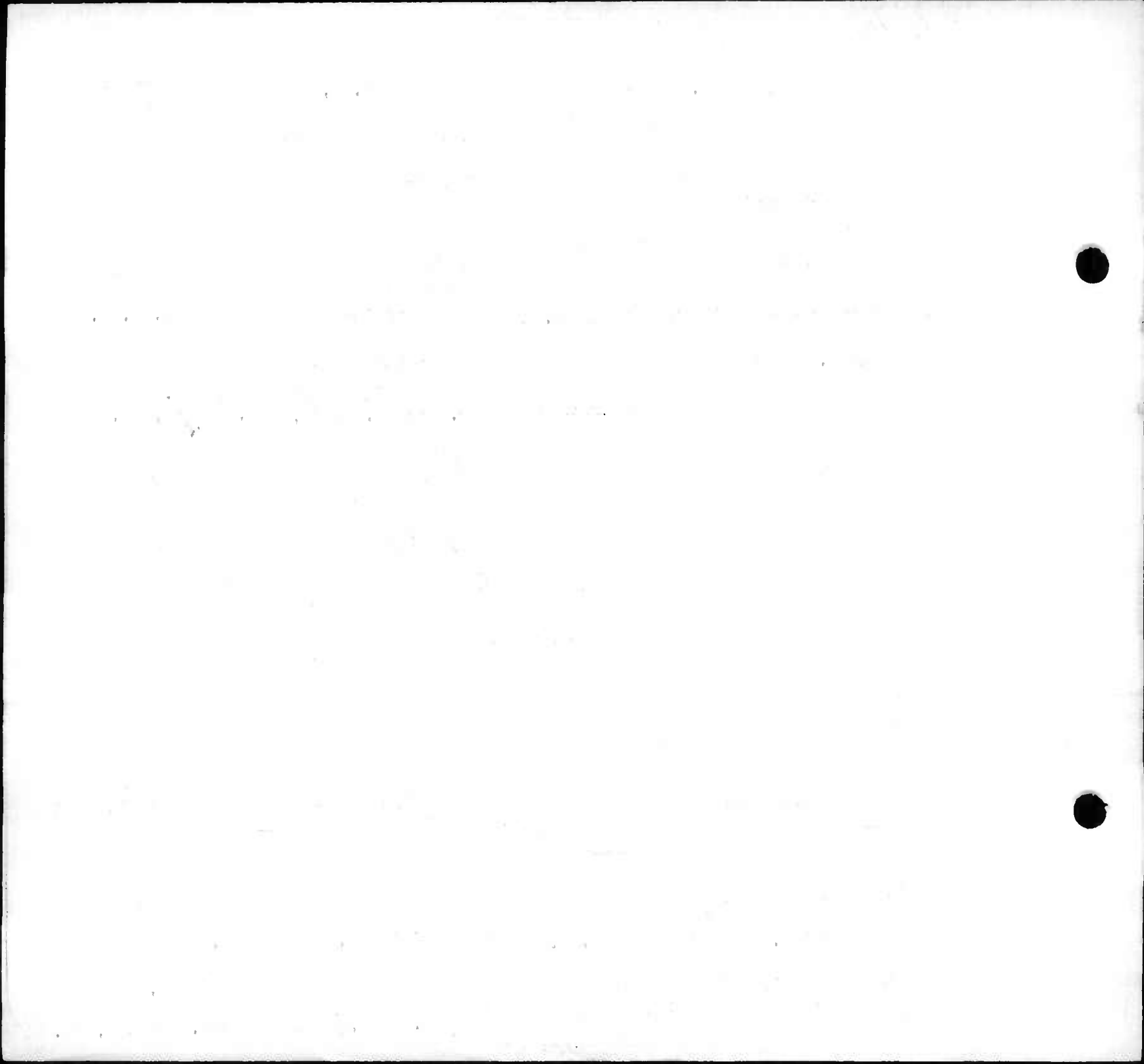
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-250		69 12330		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12330	
BIRTH NO.		1. NAME OF DECEASED Geraldine K. Vaughn (Type or Print) VAUGHN, GERALDINE				2. DATE AND HOUR OF DEATH 12 - 11 - 69 5 30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD CERTIFICATE AMENDED FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1 - 19 - 1970 Baltimore City Hospitals 21224 4940 Eastern Avenue, Baltimore, Md.		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		C. CITY OR TOWN Fort Howard		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-19-19		9. AGE (In years lost birthday) 50 yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert DeWitt		14. MOTHER'S MAIDEN NAME Grace Loucks		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-10-5935		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue 21224	
18. 180X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE RENAL OBSTRUCTION CARCINOMA CERVIX - METASTATIC		CAUSE OF DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST		(B) DUE TO, OR AS A CONSEQUENCE OF: ACUTE RENAL OBSTRUCTION		(C) CARCINOMA CERVIX - METASTATIC	
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 min									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from DEC 1 19 69 to DEC 11 19 69 , that (I) (we) last saw the deceased alive on DEC 11 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Dale N. Schumacher MD		23B. DATE SIGNED 12/11/69		23C. PHYSICIAN'S NAME (Type) DALE N. SCHUMACHER MD		23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland Baltimore City Hospitals			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Kelly		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Ave. Dundalk, Md. 21222			

Letter from Balto. City Hospitals
1-19-70 M.H.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		69 12331		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12331	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Walter M. Hoyle				2. DATE AND HOUR OF DEATH Dec. 9, 1969 7⁰⁰ P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Nursing Home						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Edgemere D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER Box 282 Oak Road			
5. SEX Male		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/10/96		9. AGE (In years last birthday) 73	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwright Foreman Bethlehem Steel Co.				10B. KIND OF BUSINESS OR INDUSTRY North Carolina		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John A. Hoyle						14. MOTHER'S MAIDEN NAME Harriet Frye			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI				16. SOCIAL SECURITY NO. 213-07-3795		17. INFORMANT (Wife) Box 282 Oak Rd. ADDRESS Mrs. Mary C. Hoyle, Ft. Howard, Md.			
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Circulatory Collapse			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours	
					(B) Systolic DUE TO, OR AS A CONSEQUENCE OF:			8 hours	
					(C) Recurrent Pneumonia & Urinary Tract Infection			-	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Multiple strokes, left hemiparesis								1 year	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 9/27 19 69 to 12/9 19 69 that (I) (we) last saw the deceased alive on 12/9 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE Albert B. Bradley						23B. DATE SIGNED 12/12/69			
23C. PHYSICIAN'S NAME (Type) Albert B. Bradley						23D. ADDRESS 4900 Belair Rd. Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/69		24C. NAME of CEMETERY or CREMATORY Gardens of Faith Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969				25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR, ADDRESS 7922 Wise Ave. Dundalk, Md.			



N-242

69 12332

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12332

BIRTH NO.

1. NAME OF DECEASED (Type or Print) RAYMOND NICHOLS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) CITY HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 9, 1969 4:35 P. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN EAST BOSTON Baltimore	
9. DATE OF BIRTH SEPT. 11, 1928		10. AGE (In years lost birthday) 41 If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) PA.		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY GAS ELECT.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) YES V W II		17. SOCIAL SECURITY NO.	
18. INFORMANT DOROTHY NICHOLS		ADDRESS ABELE	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) H12.4 Arteriosclerotic Cardiovascular Disease		CAUSE OF DEATH Arteriosclerotic Cardiovascular Disease	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 22		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/10/69	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/13/69	
24C. NAME OF CEMETERY or CREMATORY OAK LAWN CEM.		24D. LOCATION (City, town, or county) (State) BALTO. M.D.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR J. E. CORNELLY	
25C. FUNERAL DIRECTOR J. E. CORNELLY SONS		ADDRESS 300 MACE	

CHARTER BY THE STATE

OF THE DISTRICT OF COLUMBIA

FOR THE PURPOSE OF

ACADEMY OF MEDICAL EXAMINERS

OFFICE OF THE DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-366		69 12333		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12333	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) GRACE MEATREUR			
2. DATE AND HOUR OF DEATH DEC. 9 1969				2. DATE AND HOUR OF DEATH DEC. 9 1969 2 ⁰⁰ A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO.			
FULL NAME OF HOSPITAL OR INSTITUTION 90 HOUSE OF PINES M.H. BELAIR RD				C. CITY OR TOWN ESSEX D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 29 RIVERSIDE RD							
5. SEX F		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 1, 1903	
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME WM. T. BLANKENSHIP				14. MOTHER'S MAIDEN NAME MARGARET DUNCAN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 223-05-9533		17. INFORMANT HAROLD MEATREUR	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I 1538 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Carcinomatosis (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the Intestine (B) DUE TO, OR AS A CONSEQUENCE OF: (C) II Multiple fractures; Clotting; Unhealed abdominal incision & dehiscence				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/21/1969 to 12/9/1969, that (I) (we) last saw the deceased alive on 12/3/1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.							
23A. SIGNATURE Albert B Bradley				23B. DATE SIGNED 12/10/69			
23C. PHYSICIAN'S NAME (Type) ALBERT B BRADLEY				23D. ADDRESS 4900 BELAIR RD			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/11/69		24C. NAME OF CEMETERY or CREMATORY HOLLY HILL CEM.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Feltz		25C. FUNERAL DIRECTOR G. J. KOWNELLY SONS		ADDRESS 300 MALE	

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

1941

CHICAGO, ILL.

TO THE UNIVERSITY OF CHICAGO

FROM THE PHYSICS DEPARTMENT

RECEIVED

1941

1941

1941

1941

1941

1941

1941

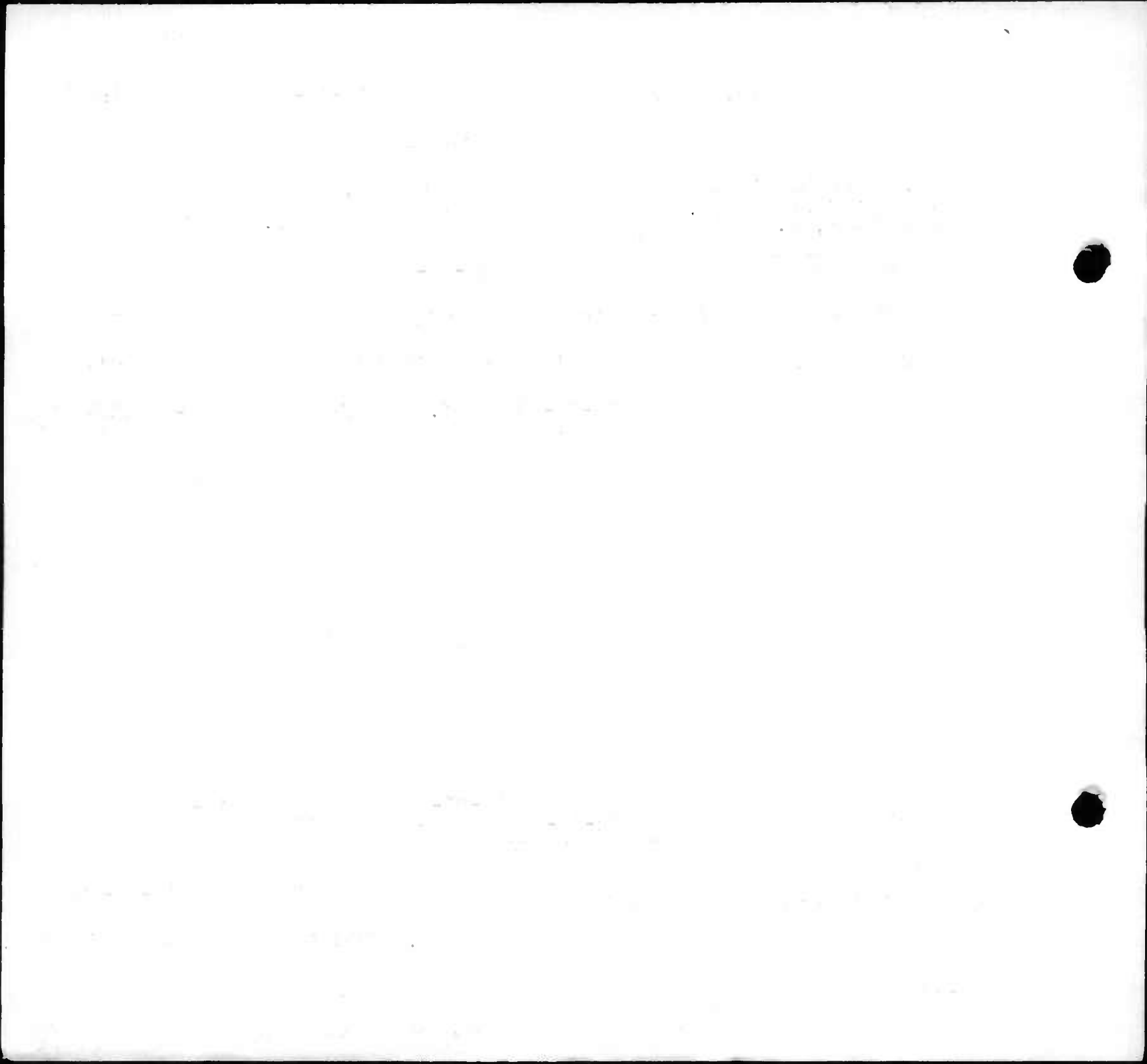
1941

1941

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

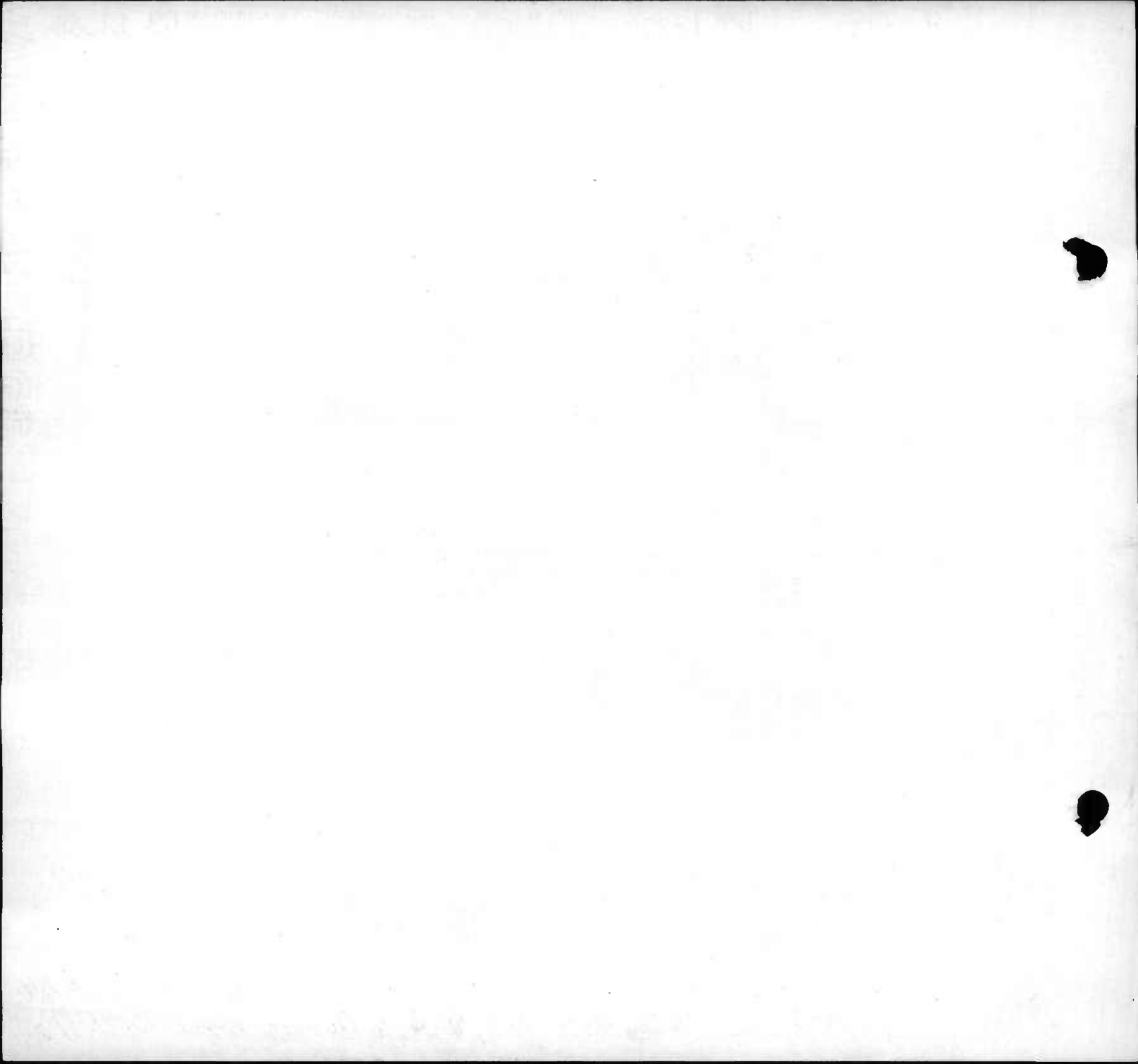
E-420		69 12334		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12334	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ELLIS, FRANCIS C				12-12-69 8:40A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE 8. COUNTY			
ST. AGNES HOSPITAL WILKENS & CATON AVE. BALTIMORE, MD. 21230				MARYLAND 2101			
5. SEX 6. RACE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> MALE WHITE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH		9. AGE (in years last birthday)	
				07-03-00		69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
RETIRED Foreman COPPERS CO				MARYLAND		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
EDWARD ELLIS DEC 'D				ANNA RIDGELL DEC 'D			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO				212-09-8486		ST. AGNES RECORDS ROOM - WILKENS & CATON AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		5 day	
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Diabetes mellitus		X years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 12-06-1969 to 12-12-1969 that (I) (we) last saw the deceased alive on 12-12-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Laurence R. Gallagher MD				12-12-69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				ST. AGNES HOSP WILKENS & CATON AVE.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12/16/69		Glen Haven Cem.		Glenhorne Ind.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 15 1969		Robert E. Taylor		John J. Brown		901, Hallway St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

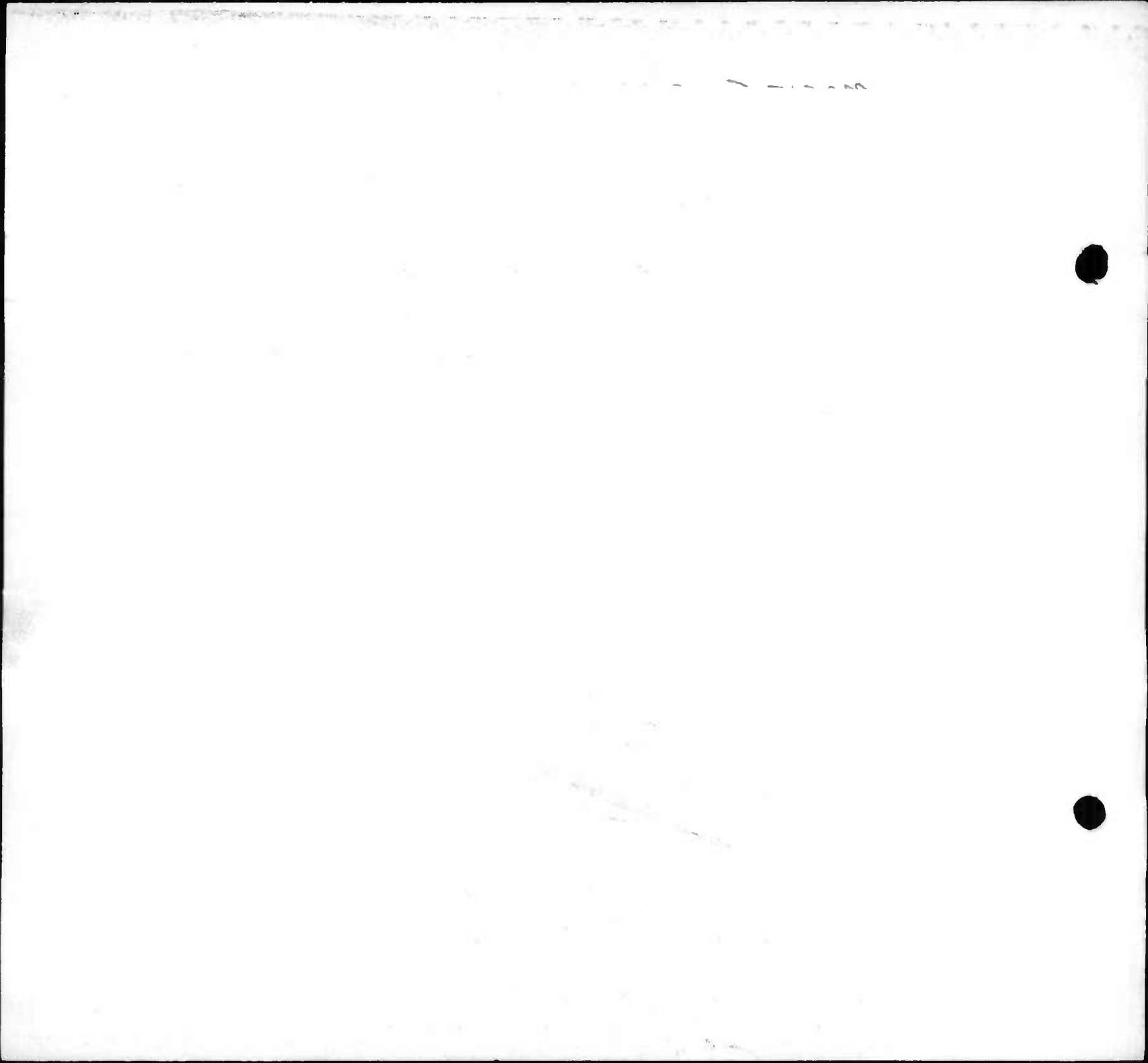
F-260		69 12335		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12335	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) GROVE H. FISHER				2. DATE AND HOUR OF DEATH 12/8/69 4 ¹⁶ A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY				1307	
FULL NAME OF HOSPITAL OR INSTITUTION UNION MEMORIAL HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE MD. 21218		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3750 HICKORY AVE		5. SEX MALE		6. RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/9/96	
9. AGE (In years lost birthday) 73		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10B. KIND OF BUSINESS OR INDUSTRY Gas & Elect Co		11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Fisher		14. MOTHER'S MAIDEN NAME Mary Wareheim		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 212 07 612913		17. INFORMANT Mrs Charles Groves Fisher 3648 Hickory Ave	
18. 410.9 I		CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE CARDIO-PULMONARY ARREST					
(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				(B) ACUTE MYOCARDIAL INFARCTION					
ANTECEDENT CAUSES				(C) ASCVD					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12/8/69 to 12/8/69, that (I) (we) lost saw the deceased alive on 12/8/69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Ronald M. Legum M.D.				23B. DATE SIGNED 12/8/69					
23C. PHYSICIAN'S NAME (Type) RONALD M. LEGUM M.D.		23D. ADDRESS UNION MEMORIAL HOSPITAL BAL MD							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 11 Dec 69		24C. NAME OF CEMETERY or CREMATORY St Mary's Cem (Hempden)		24D. LOCATION (City, town, or county) (State) Baltimore Md			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Burgdy Funeral Home Baltimore		25D. ADDRESS 36 Home Md			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-155		69 12336		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 69 12336	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) MARIE G. CHAFFMAN				12/11/69 3:05 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) MERCY HOSPITAL				A. STATE MD. B. COUNTY BALTO. 5300			
				C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 804 Regatta Ave.			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/1/1905		9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salad Lady			10B. KIND OF BUSINESS OR INDUSTRY McCrorys		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Fredrick W. Franke				14. MOTHER'S MAIDEN NAME Minnie Molte			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-10-5069		17. INFORMANT Mr. Louis F. Chaffman		ADDRESS Above
18. 154.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary Embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Polio over the				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary Embolism (B) Polio over the DUE TO, OR AS A CONSEQUENCE OF: (C) Past op - miles hunter job		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 12/4/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of Rectum		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/1/69 to 12/11/69 that (I) (we) last saw the deceased alive on 12/11/69 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE W. B. REVER, JR., M.D.				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) Wm. B. REVER, JR. M.D.				23D. ADDRESS 801 PROVIDENCE RD. Balt. Md. 21204			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Harvey Md.	
25A. DATE RECD BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR John J. Cavanagh		ADDRESS St. Hollings	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-520 69 12337		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12337	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) CHARLES MANNS SR.		2. DATE AND HOUR OF DEATH Dec. 11, 1969 2:15 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2788			
FULL NAME OF HOSPITAL OR INSTITUTION 5231 Glenmore Ave. Baltimore Md 21215		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5231 Glenmore Ave.					
5. SEX m	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/16/85	9. AGE (in years last birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME CHARLES HENRY MANNS		14. MOTHER'S MAIDEN NAME Henrietta Crutcherman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Unknown		16. SOCIAL SECURITY NO. 212-18-7205		17. INFORMANT CHARLES MANNS, JR. ADDRESS 3319 Buckleth Ave	
18. 410.91		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASHO DUE TO, OR AS A CONSEQUENCE OF: (C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 19 68 to Dec 19 69 that (I) (we) last saw the deceased alive on Nov 30 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Joseph J. Zerna		23B. DATE SIGNED 12/11/69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 15/69		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
24D. LOCATION Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Farber, M.D.		25C. FUNERAL DIRECTOR Griffith-Elkman 11297 Caroline St	

02C-711



69 12338

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12338

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Jeff Davis				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2033 E. Biddle St.				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 12 69 10:20 p.m.			
6. SEX male				7. RACE colored			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN Baltimore			
9. DATE OF BIRTH March 23, 1920				10. AGE (In years last birthday) 48			
11. BIRTHPLACE (State or foreign country) Rocky Mt. N.C.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME William Davis				14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 807			
15. MOTHER'S MAIDEN NAME Emma Jones				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.			
17. SOCIAL SECURITY NO.				18. INFORMANT Marie Jones ADDRESS 2033 E. Biddle St.			
19. 571.8				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(C)			
20A. DATE OF OPERATION 2				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) yes							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
DATE SIGNED 12/13/69							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/16/69			
24C. NAME OF CEMETERY or CREMATORY MT. Calvary Cem.				24D. LOCATION (City, town, or county) (State) A.A. County Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969				25B. NAME OF REGISTRAR Robert E. Salter			
25C. FUNERAL DIRECTOR William B. Edelman				ADDRESS 1129 N. CAROLINE			

ACADEMICY BOND

WILLIAM P. HARRIS

PAID TO THE

1000

1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12339
Z-420 BIRTH NO.		69 12339 CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) Samuel Gayles		2. DATE AND HOUR OF DEATH 10:45 A.M. 12/12/69 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 3808 Woodridge Rd.		A. STATE MD. B. COUNTY BALTIMORE		
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 3808 Woodridge Rd.				
5. SEX M.	6. RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 9, 1907	9. AGE (In years lost birthday) 62
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEEL Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GLOUCESTER, VA.
13. FATHER'S NAME Simuel Gayles		14. MOTHER'S MAIDEN NAME Elizabeth Cook		
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-07-0640		17. INFORMANT Flossie Florence Gayles
18. 1621 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinomatosis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of the Lung (B) DUE TO, OR AS A CONSEQUENCE OF: Yrs (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Early 1969 to 12-12-1969 , that (I) (we) last saw the deceased alive on 12-11-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE James J. McPhillips MD		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/13/69
23C. PHYSICIAN'S NAME (Type) JAMES J. McPHILLIPS MD		23D. ADDRESS 2E READ ST BALTO MD 21202		
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 12/16/69		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park Arbutus, Md.
24D. LOCATION (City, town, or county) (State) BALTIMORE MD				
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Gayles		25C. FUNERAL DIRECTOR Spiller & B. Edickson

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12340

CERTIFICATE OF DEATH

REG. NO.

69 12340

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

HARMON SPENCE, SR.

2. DATE AND HOUR OF DEATH

Dec. 11, 1969 1 0130 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE MD. B. COUNTY

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒ No ☐

E. STREET AND NUMBER

221 N. FREMONT AVE, #904

5. SEX

M

6. RACE

N

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

2-14-96

9. AGE (In years last birthday)

73

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Stock Clerk Retired

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

NOAH SPENCE

14. MOTHER'S MAIDEN NAME

OLIVIA PENN

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

HOSPITAL RECORD

ADDRESS

18. 204.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE Pharyngeal lymphatic leukemia
DUE TO, OR AS A CONSEQUENCE OF:

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 MONTHS

(B) Chronic Lymphocytic Leukemia
DUE TO, OR AS A CONSEQUENCE OF:

2 years

(C) also Gangrene (D) foot probably 2° to above

3 months

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

CHF + ASCVD

10 years

19A. DATE OF OPERATION

none

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-27-69 1969 to 12-11 1969 that (I) (we) last saw the deceased alive on 12-11 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Frederick N. Pearson MD

Attending Phys. ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

12-11-69

23C. PHYSICIAN'S NAME (Type)

FREDERICK N. PEARSON, MD

23D. ADDRESS

Univ. of Md. Hospital

24A. BURIAL CREMATION REMOVAL (Specify)

Burial

24B. DATE

12/15/69

24C. NAME OF CEMETERY OR CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

25B. NAME OF REGISTRAR

Robert E. Gable, MD

25C. FUNERAL DIRECTOR

Chas. H. Jewell

ADDRESS

319 N. Schroeder

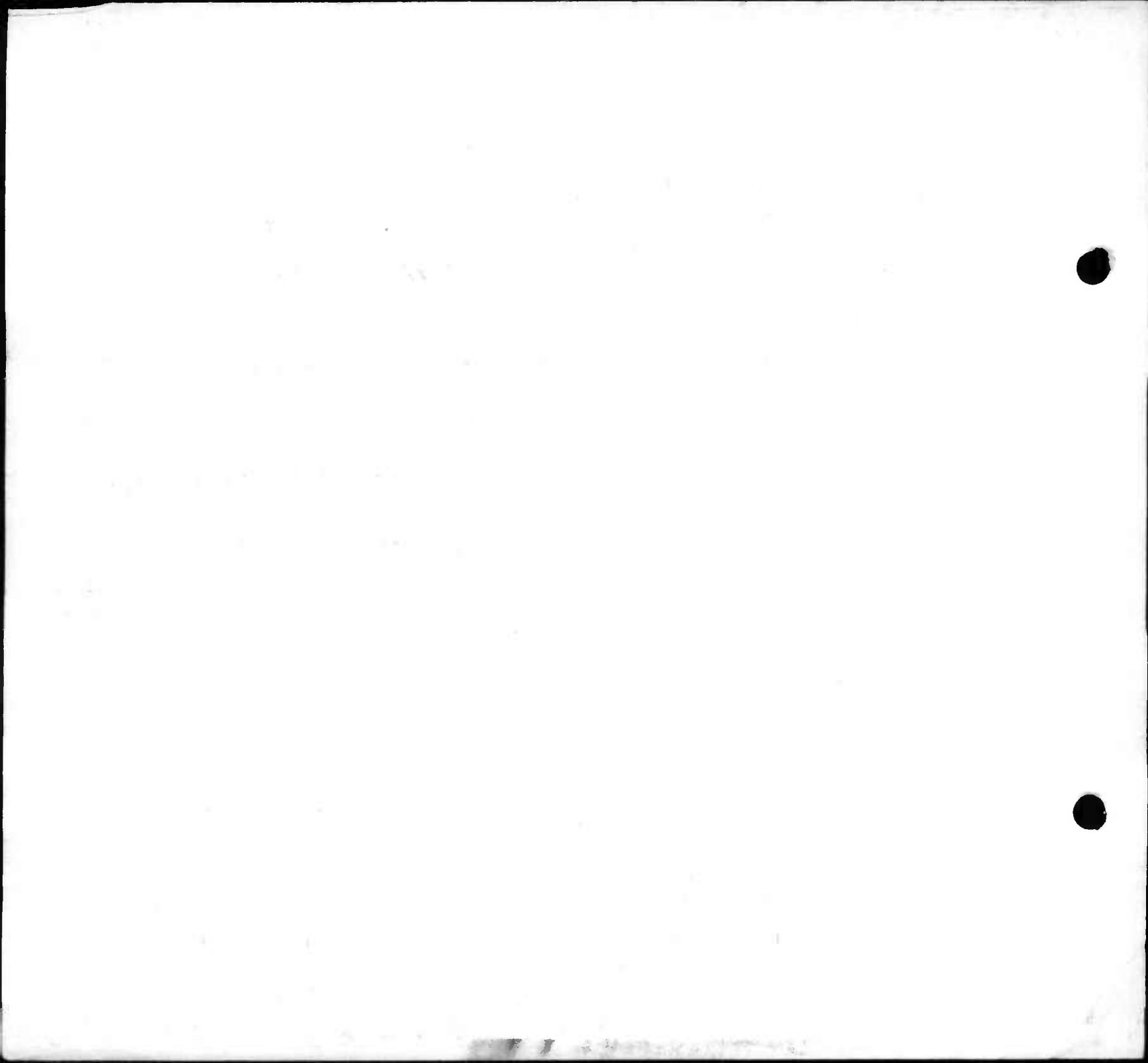
T-460

1

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

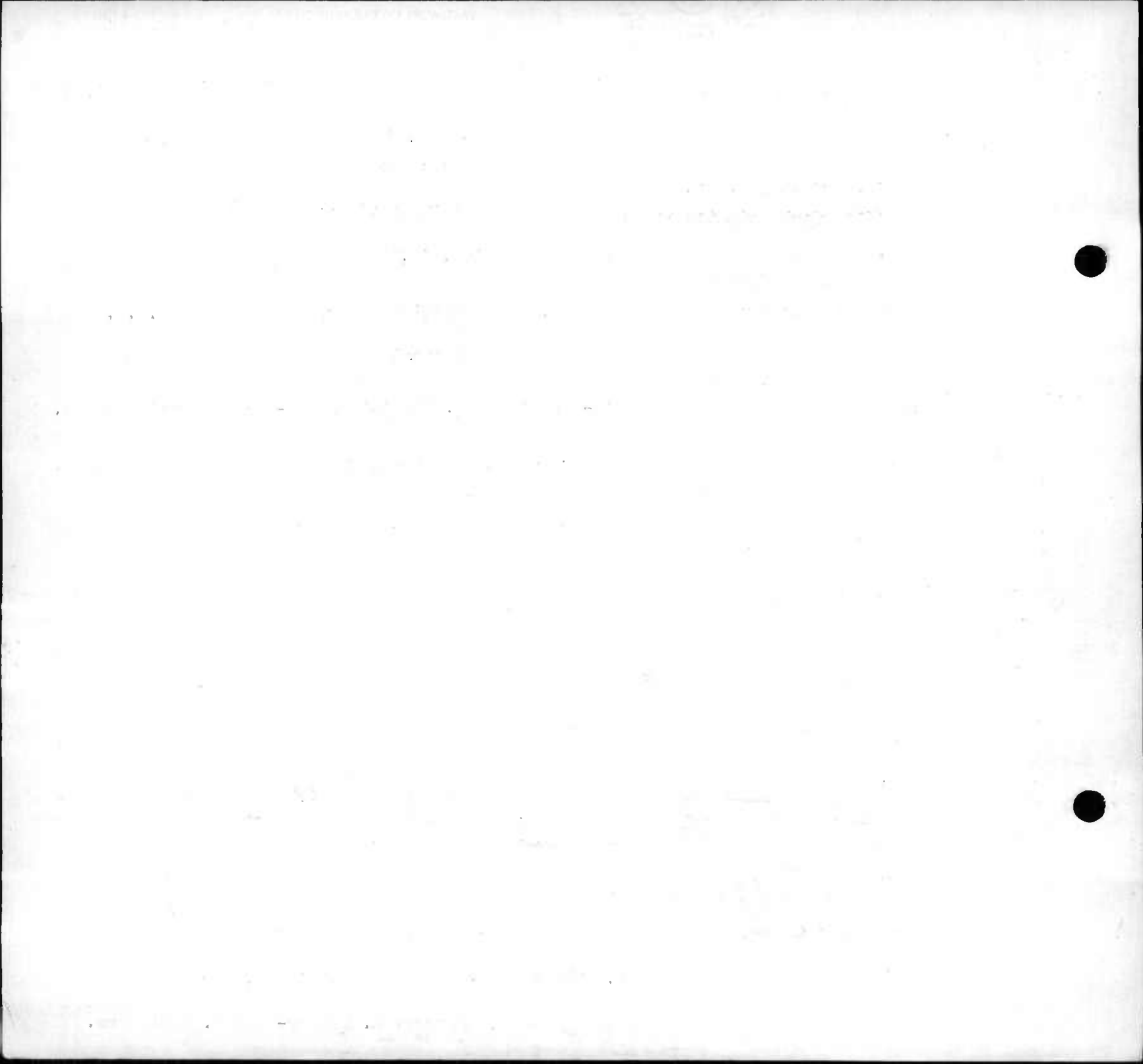
BALTIMORE CITY HEALTH DEPARTMENT				69 12341		REG. NO. 69 12341	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Walter Taylor</i>				2. DATE AND HOUR OF DEATH <i>12/10/69 8 PM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>33 Johns Hopkins Hospital</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>808</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 Johns Hopkins Hospital</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>1043 N. BROADWAY</i>			
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/8/91</i>	9. AGE (In years lost birthday) <i>78</i>	10. Under 1 Tr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>				10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Vicksburg, Miss.</i>	
13. FATHER'S NAME <i>CRAWFORD TAYLOR</i>				14. MOTHER'S MAIDEN NAME <i>MAGGIE TAYLOR</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>216-050155</i>		17. INFORMANT <i>Maude Taylor</i>	
18. <i>329.91</i>				ADDRESS <i>1043 N. Broadway</i>			
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <i>2</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i> 20A. AUTOPSY? (Yes or No) <i>YES</i> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>—</i>				(A) IMMEDIATE CAUSE <i>Cardio-Respiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>G.I. Bleeding, Aortic Aneurysm, Aspiration</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>Pneumonia, Subendocardial Ischemia, Hypertension</i> <i>Shock</i>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>—</i>			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>—</i>				21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>—</i>			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? <i>—</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>12/9</i> 19 <i>69</i> to <i>12/10</i> 19 <i>69</i> that (I) (we) last saw the deceased alive on <i>8 PM</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Rein Saral</i>				23B. DATE SIGNED <i>12/10</i>			
23C. PHYSICIAN'S NAME (Type) <i>REIN SARAL</i>				23D. ADDRESS <i>THE JOHNS HOPKINS HOSPITAL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>				24B. DATE <i>12-15-69</i>			
24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn</i>				24D. LOCATION <i>BALTO.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 15 1969</i>				25B. NAME OF REGISTRAR <i>Robert E. Taylor, Jr.</i>			
25C. FUNERAL DIRECTOR <i>Therrell B. Oden</i>				ADDRESS <i>BALTO. MD</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>S-530 69 12342</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12342</p>	
<p>BIRTH NO.</p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>1. NAME OF DECEASED (Type or Print) LULA SMITH</p>		<p>12-9-69 1:05 P.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p>Pleasant Manor Conv. Home</p> <p>4615 Park Heights Avenue</p>		<p>A. STATE Maryland</p> <p>B. COUNTY</p>	
<p>5. SEX Female</p>		<p>6. RACE Negro</p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH Aug. 15, 1877</p>	
<p>9. AGE (In years last birthday) 92</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator</p>	
<p>11. BIRTHPLACE (State or foreign country) Baltimore Maryland</p>		<p>12. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>13. FATHER'S NAME Granison Hose</p>		<p>14. MOTHER'S MAIDEN NAME Rachael Woods</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 215-18-2144</p>	
<p>17. INFORMANT Mrs. Virginia Jones-</p>		<p>ADDRESS 1015 Providence St.</p>	
<p>18. CAUSE OF DEATH</p> <p>412.41</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>Cardiac arrest</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>Arteriosclerotic Cardiovascular Disease</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p>3 min</p> <p>year,</p>	
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (the deceased) attended the deceased from 11-26 1969 to 12-9 1969, that (I) was lost saw the deceased alive on 12-9 1969 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) was (did) not view the body after death.</p>			
<p>23A. SIGNATURE</p> <p>Frank G. Kuehn</p>		<p>23B. DATE SIGNED</p> <p>12/9/69</p>	
<p>23C. PHYSICIAN'S NAME (Type)</p> <p>FRANK G. KUEHN</p>		<p>23D. ADDRESS</p> <p>721 Med Arts Bldg Balto 1 md</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p>Burial</p>		<p>24B. DATE</p> <p>12/11/1969</p>	
<p>24C. NAME OF CEMETERY OR CREMATORY</p> <p>Mt. Auburn Cemetery</p>		<p>24D. LOCATION</p> <p>Baltimore, Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT.</p> <p>DEC 15 1969</p>		<p>25B. NAME OF REGISTRAR</p> <p>Herbert E. Nutter-3035 W. North Ave.</p>	
<p>25C. FUNERAL DIRECTOR</p>		<p>ADDRESS</p>	



B-400

69 12343

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12343

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

MERIBAH BELL

2. DATE

Known ☒

Month

Day

Year

Hour

DEATH

Estimated ☐

12

4

69

11:50 PM

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Lutheran Hospital D.O.A.

3. DATE

Month

Day

Year

Hour

PRONOUNCED DEAD

December 4, 1969 11:50 PM

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

1506

6. SEX

Female

7. RACE

Negro

8. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

4-26-07

10. AGE (In years

last birthday)

62

If Under 1 Yr. If Under 24 Hrs.

Months Days Hours Min.

E. STREET AND NUMBER

2711 Clifton Ave.

11. BIRTHPLACE (State or foreign country)

Ga.

12. CITIZEN OF

WHAT COUNTRY?

USA

13. FATHER'S NAME

William H. Reeves

14A. USUAL OCCUPATION (Give kind of work

done during most of working life, even if retired)

Fur Finisher

14B. KIND OF BUSINESS OR INDUSTRY

Fur Co.

15. MOTHER'S MAIDEN NAME

Lucy Hunter

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL

SECURITY NO.

5-2-2

18. INFORMANT

ADDRESS

Mr. Leslie A Bell

3711 Clifton Ave.

19.

41212

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, ashenia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF:(B) _____
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

NO

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinionresulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Isidore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/5/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-10-69

24C. NAME OF CEMETERY or CREMATORY

South View Cemetery

24D. LOCATION (City, town, or county)

Atlanta

(State)

Ga.

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

Nutter Funeral Home

ADDRESS

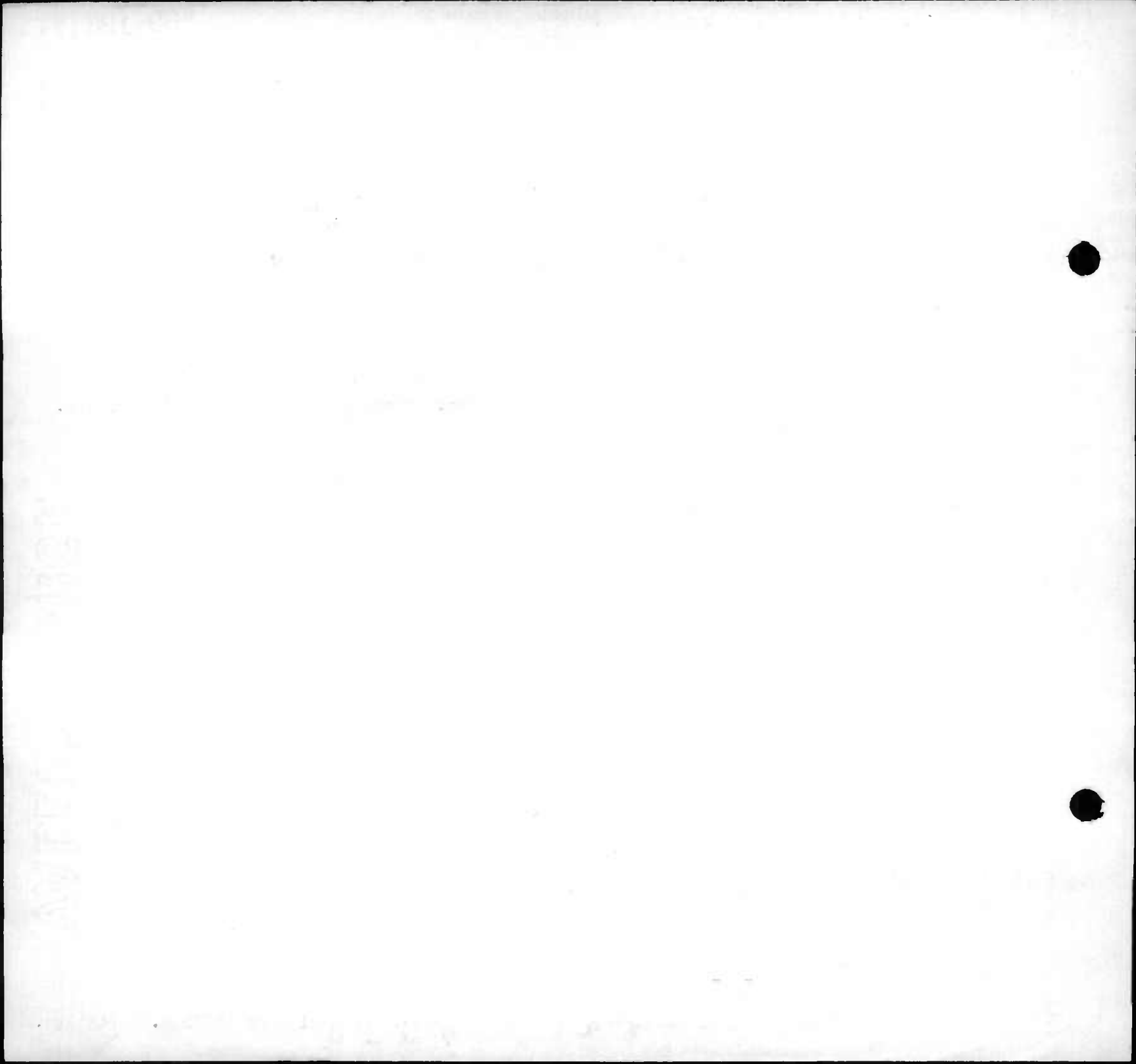
3035 W. North Ave.

WALLLEY PROFILES

FUNERAL DIRECTOR: IMPORTANT

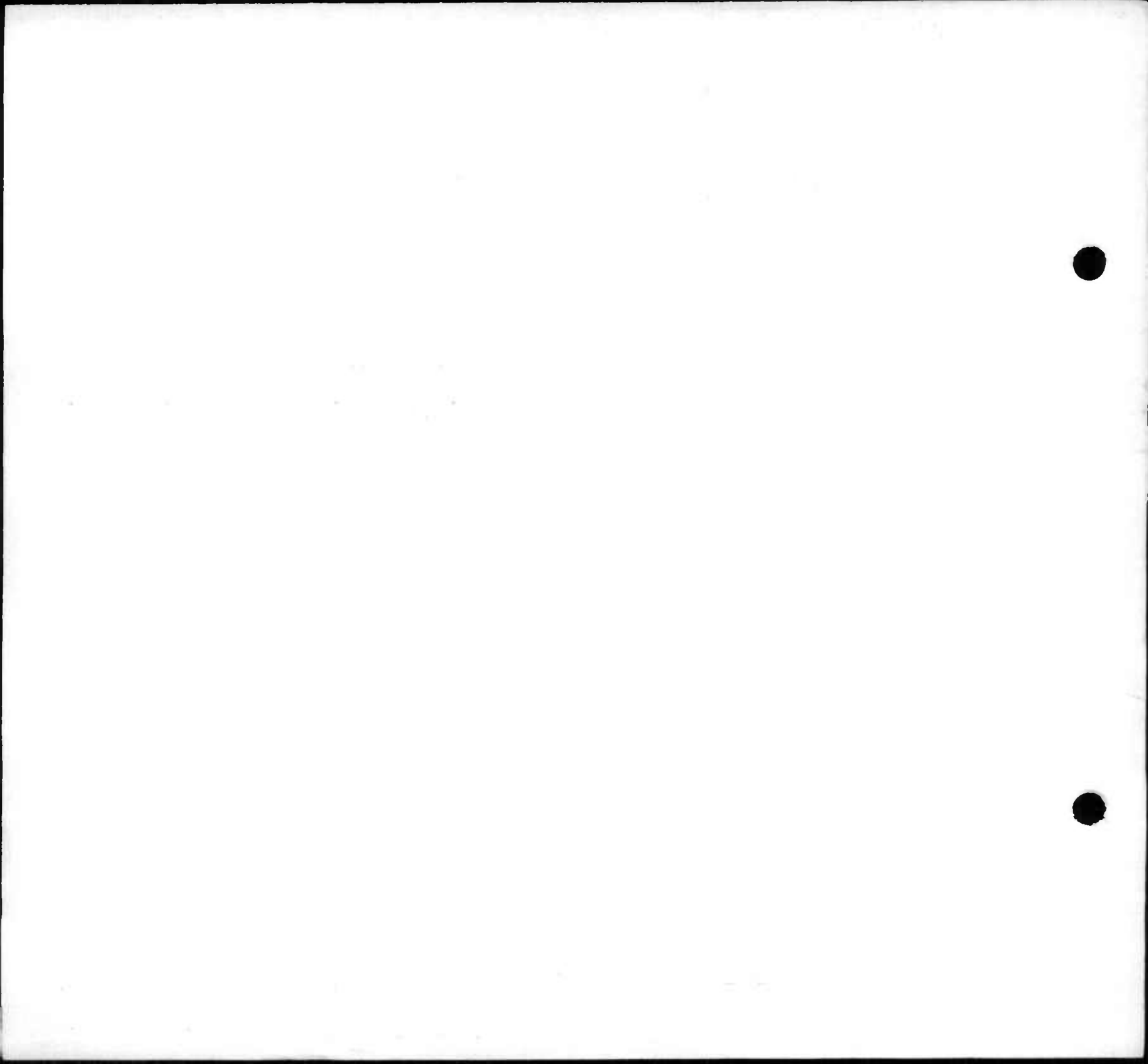
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-652		69 12344		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12344	
M.E. CASE NO. LAWRENCE				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type as Print) <u>CLEVELAND LAWRENCE</u>				2. DATE AND HOUR OF DEATH <u>12/12/69</u> <u>19:35</u> P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>48 Maryland General Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CITY</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u> D. STREET ADDRESS (If rural, give location) <u>2921 WINDSOR AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11/20/10</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEEL WORKER</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>		11. BIRTHPLACE (State or foreign country) <u>SOUTH CAROLINA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>JAMES LAWRENCE</u>				14. MOTHER'S MAIDEN NAME <u>LORENA GOODMAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>251-26-5027</u>		17. INFORMANT <u>Mrs. Lorena Lawrence</u>		ADDRESS <u>2921 Windsor Ave.</u>	
18. <u>432.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <u>BASILAR ARTERY THROMBOSIS</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>16 DAYS</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>CARCINOMA OF THE LARYNX</u>						<u>3 MONTHS</u>	
19A. DATE OF OPERATION <u>11/26/69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>CARCINOMA LARYNX</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>NONE</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NONE</u>			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>NONE</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> <u>N.A.</u>		21F. HOW DID INJURY OCCUR? <u>N.A.</u>			
22. I certify that (I) (this hospital) attended the deceased from <u>11/12/69</u> to <u>12/12/69</u> , that (I) (we) last saw the deceased alive on <u>12/12/69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Brent C. Sanders M.D.</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>12/12/69</u>	
23C. PHYSICIAN'S NAME (Type) <u>BRENT C. SANDERS M.D.</u>				23D. ADDRESS <u>827 Linden Ave BALTO. MD.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-17-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Nutter Funeral Home</u>		ADDRESS <u>3035 W. North Ave.</u>	



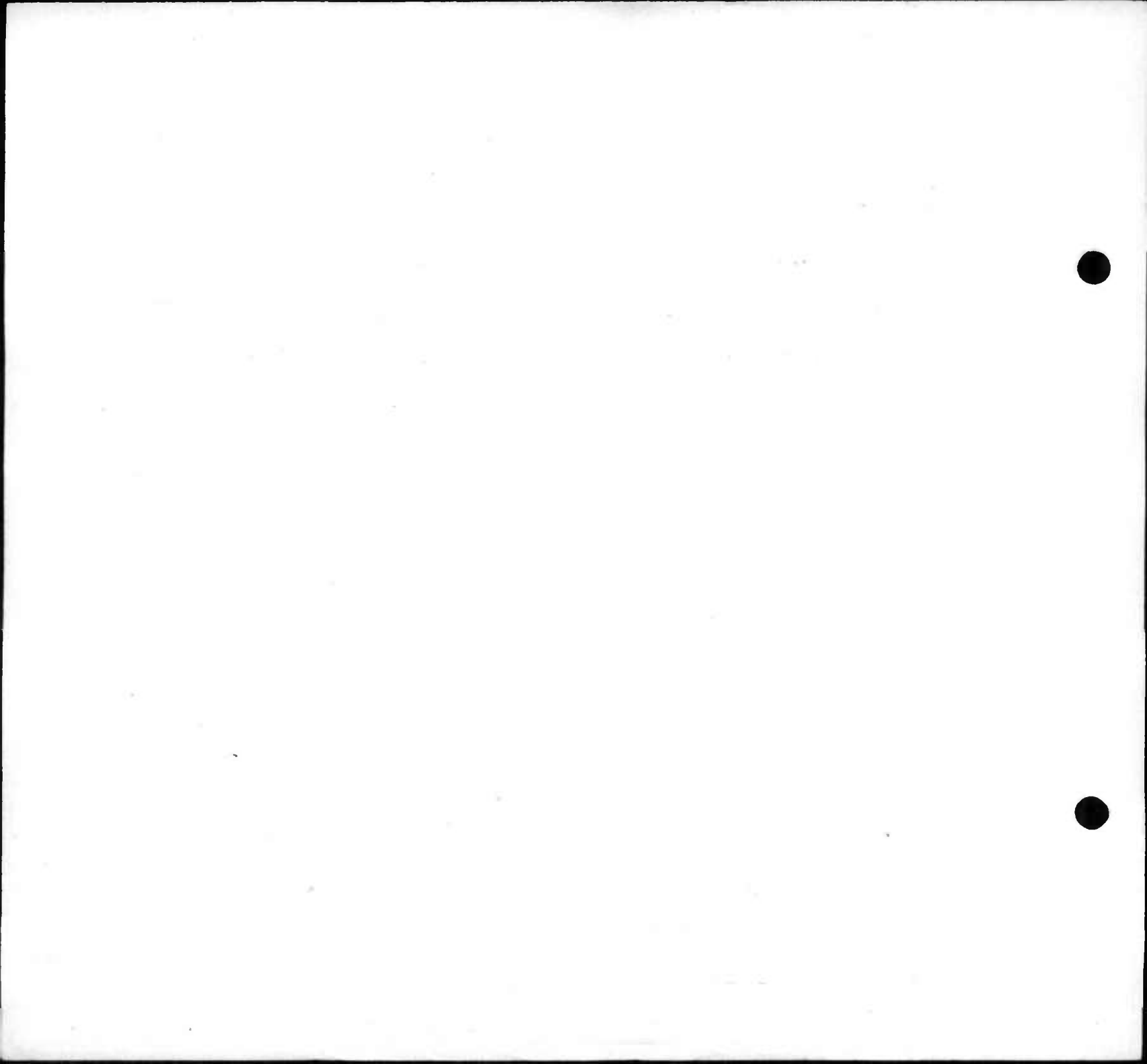
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-400		69 12345		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12345	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) HALL, MARY W.				2. DATE AND HOUR OF DEATH 12-14-69 5:15 a.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 PROVIDENT HOSPITAL 1514 Division St.				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 1303 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2529 McCulloh St.			
5. SEX F	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-20-09	9. AGE (In years last birthday) 60	If Under 1 Yr. Months	If Under 1 Yr. Days	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Martin H. Whiten			14. MOTHER'S MAIDEN NAME Amy Johnson				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Rev. Richard P. Hall 2529 Mc Culloh St. Hosp. Record		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162-1 I CAUSE OF DEATH (A) IMMEDIATE CAUSE Co Lung DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Dec 8 19 69 to Dec. 15 19 69 that (I) (we) last saw the deceased alive on Dec. 14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Francisco S. Corpey				23B. DATE SIGNED 12-14-69		23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-18-69		24C. NAME of CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore Co. Md.	
25A. DATE RECD BY HEALTH DEPT. DEC 15 1969				25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Nutter Funeral Home 3035 W. North Ave.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12346</u>
69 12346 CERTIFICATE OF DEATH				
1. NAME OF DECEASED (Type or Print) <u>Carrie E. Robinson</u>		2. DATE AND HOUR OF DEATH <u>12/14/69</u> <u>1/4 M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BON SECOURS HOSPITAL</u> <u>4 BALTIMORE, Md., 21223</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>MARYLAND</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1804 LAURETTA AVE. BALTO. Md 233</u>		
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/11/02</u>	9. AGE (In years last birthday) <u>67</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic Work</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>- Hazzard Presberry</u>		
14. MOTHER'S MAIDEN NAME <u>A Sarah E. Sprigg</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Charles Robinson</u> ADDRESS <u>1804 Lauretta Ave.</u>		
18. <u>5-71.914-250.9</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>HEMATENESIS</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>CIRRHOSIS -</u> <u>(HEPATIC FAILURE) AND UREMIA</u> <u>REPEATED CVA. AND DIABETES</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>4 YRS</u> <u>4 YRS.</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>
21D. TIME OF INJURY (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>
22. I certify that (I) (this hospital) attended the deceased from <u>October 24</u> 19 <u>69</u> to <u>December 14</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>December 14</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Orathai Thirawat</u> MD. DEGREE		23B. DATE SIGNED <u>12/14/69</u>		23C. PHYSICIAN'S NAME (Type) <u>ORATHAI THIRAWAT MD</u>
23D. ADDRESS <u>BON SECOURS HOSPITAL, BALTO. Md. 21223</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>12-19-69</u>	24C. NAME of CEMETERY or CREMATORY <u>Burkley Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Darlington Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Bailey, M.D.</u>		25C. FUNERAL DIRECTOR <u>Natter Funeral Home</u> ADDRESS <u>3035 W. North Ave.</u>



1

7-250

69 12347

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12347

BIRTH NO.		1. NAME OF DECEASED (Type or Print) GLADYS TYSON		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 10 69 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION JOHNS HOPKINS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 10, 1969 8:39 A.M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1001	
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-8-26		10. AGE (In years last birthday) 43		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 928 E. Eager Street	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Ernest Robinson	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME ?	
18. INFORMANT Miss Linda Tyson		ADDRESS 928 E. Eager St.			
19. 199.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTICIPATED CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Metastatic Carcinoma (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes (Partial)	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> m. (Partial)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE EXAMINER'S NAME (Type) Ronald N. Kornblum, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/10/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-69		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk.	
24D. LOCATION (City, town, or county) (State) Baltimore Co. Md		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR 25C. FUNERAL DIRECTOR Nutter Funeral Home	
25D. ADDRESS 3035 W. North Ave.					

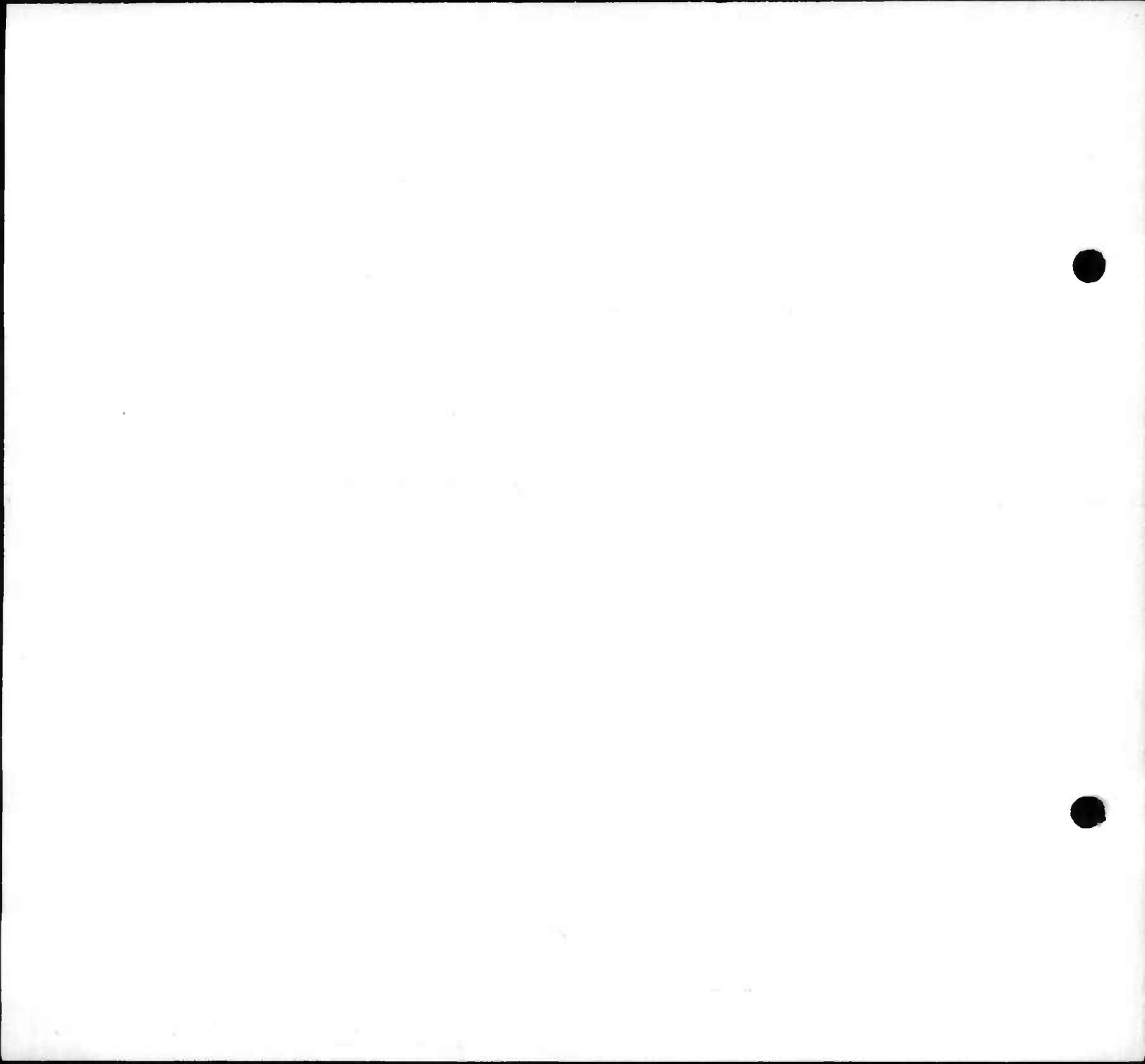
ACADEMY BOND

[Handwritten signature]

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

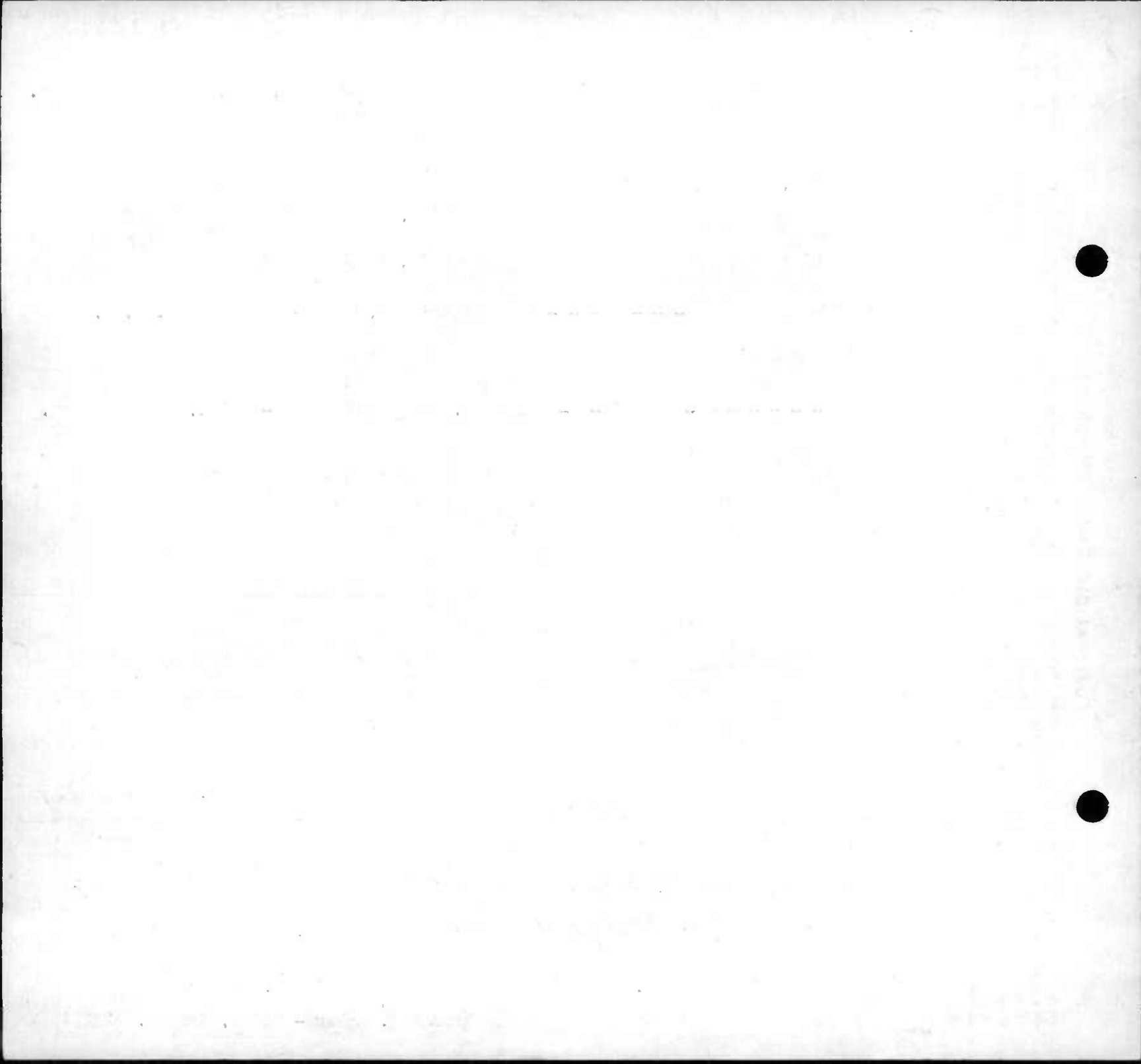
G-360		69 12348		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12348	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) EATHER, EMMA					
2. DATE AND HOUR OF DEATH 12-11-69 200 P. M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL OF BALTIMORE					
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 2717				C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER 3311 Payton Av. #15				5. SEX F 6. RACE N 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					
8. DATE OF BIRTH 12/6/99 9. AGE (in years last birthday) 70				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic Worker					
11. BIRTHPLACE (State or foreign country) Md.				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Eugene Nichols				14. MOTHER'S MAIDEN NAME Jennie Conway					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. Alice Lucas 3311 Payton Ave.			
18. 412.21 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE W. M. M. DUE TO, OR AS A CONSEQUENCE OF:					
				(B) Nephrosclerosis & Chronic renal failure. DUE TO, OR AS A CONSEQUENCE OF:					
19. DATE OF OPERATION 0 19A. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)					
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/22/69 19 to 12/11/69 19 that (I) (we) last saw the deceased alive on 12/11/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE [Signature]				23B. DATE SIGNED 12/11/69		23C. PHYSICIAN'S NAME (Type) RAFAEL LEVINS, MD DEGREE MD			
23D. ADDRESS Sinai Hospital				24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-15-69 24C. NAME OF CEMETERY or CREMATORY West Liberty Cemetery 24D. LOCATION (City, town, or county) (State) West Liberty Md.					
25A. DATE REG. BY HEALTH DEPT. DEC 15 1969 25B. NAME OF REGISTRAR [Signature]				25C. FUNERAL DIRECTOR ADDRESS Nutter Funeral Home 3035 W. North Ave.					



FUNERAL DIRECTOR: IMPORTANT

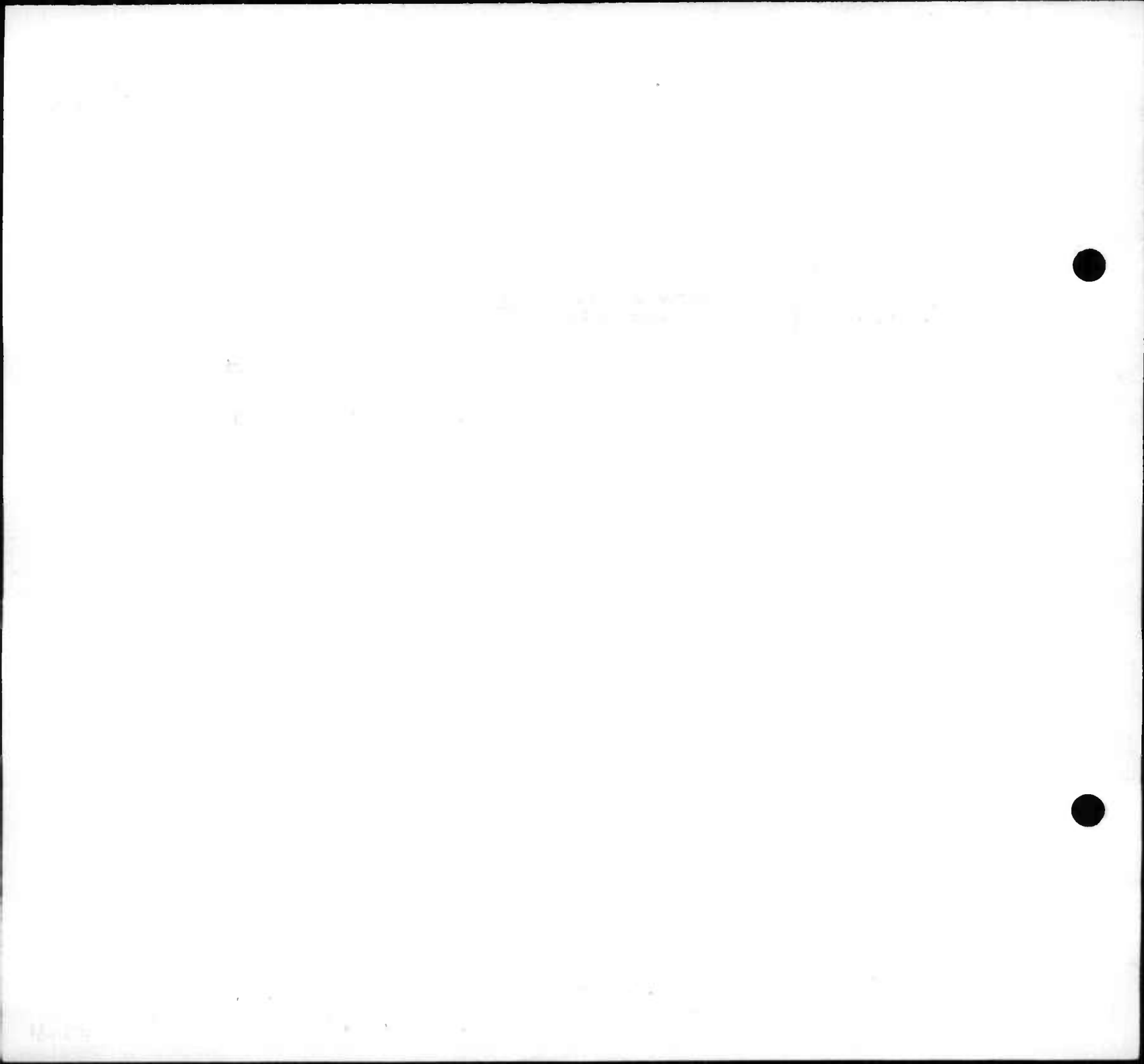
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>P-242</p> <p style="font-size: 24pt; font-weight: bold;">69 12349</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12349</p>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Josephine Pszczolkowski			
		2. DATE AND HOUR OF DEATH December 11, 1969 12:20 p.m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 631 S. Lakewood Avenue		A. STATE Maryland 8. COUNTY 103	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 631 S. Lakewood Avenue #21224			
S. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 10, 1895	9. AGE (In years last birthday) 74
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Francis Goralski		14. MOTHER'S MAIDEN NAME Katherine		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-05-2817		17. INFORMANT ADDRESS Mrs. Anna Gladkowski - 631 S. Lakewood Ave.	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic Heart Disease		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (B) DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis (C) -----			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Aneurysm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from December 12, 1969 to October 1969 , that (I) (was) lost saw the deceased alive on October 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Melito M. Torres, M.D.				23B. DATE SIGNED 12-12-69	
23C. PHYSICIAN'S NAME (Type) MELITO M. TORRES, M.D.				23D. ADDRESS 441 S. ELLWOOD AVE., BALTO, MD 21224	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			
25B. NAME OF REGISTRAR George A. Weber		25C. FUNERAL DIRECTOR ADDRESS 705 S. Ann St. #21231			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

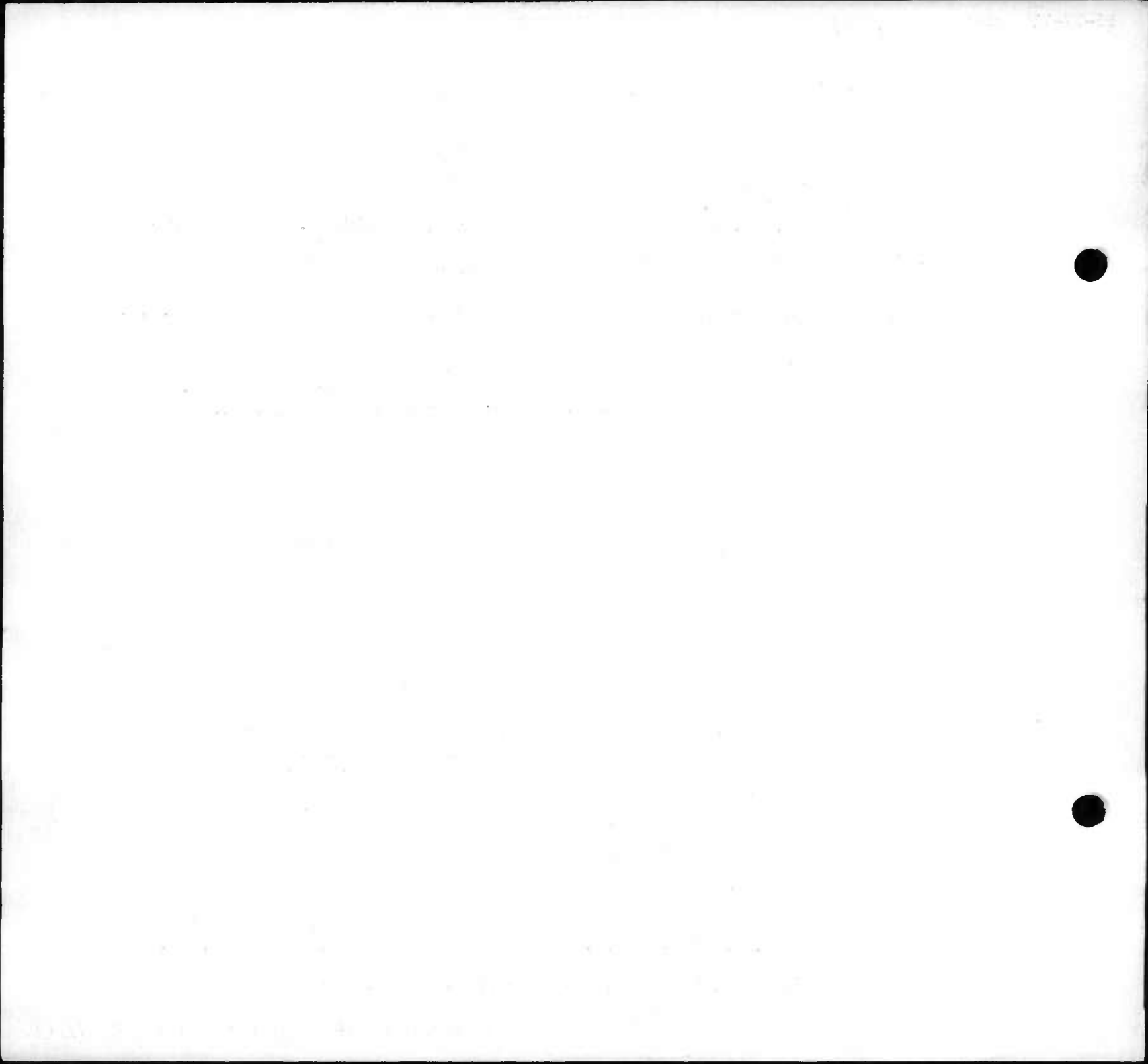
I-2201300 69 12350		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12350	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Keith Mr. Stanley P. Stanley D. Iszkiewicz		2. DATE AND HOUR OF DEATH 12/12/69. 5:40 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 35 Church Home and Hospital.		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND. B. COUNTY 1-04		C. CITY OR TOWN BALTIMORE.	
FULL NAME OF HOSPITAL OR INSTITUTION		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 2213 Winterling Court (31)	
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-20-07	9. AGE (In years last birthday) 62	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHIPFITTER.		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL SHIPYARD		11. BIRTHPLACE (State or foreign country) MARYLAND.	
12. CITIZEN OF WHAT COUNTRY? AMERICA.		13. FATHER'S NAME Joseph Keith + Joseph Iszkiewicz		14. MOTHER'S MAIDEN NAME Juras Catherine Juras	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. 215-09-9175		17. INFORMANT Mrs. Helen Iszkiewicz 2213 Winterling Court	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 162.1 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(A) IMMEDIATE CAUSE Carcinoma of the lung. DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-16 1969 to 12/12 1969 that (I) (we) last saw the deceased alive on 12-12 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Ricardo M. Tuxson M.D.		23B. DATE SIGNED 12/12/69		23C. PHYSICIAN'S NAME (Type) Ricardo M. Tuxson M.D.	
23D. ADDRESS 100 N. Broadway 21231					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/69		24C. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	
24D. LOCATION Baltimore, Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR George A. Weber		25C. FUNERAL DIRECTOR ADDRESS 705 South Ann Street #21231	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

5-124 BIRTH NO. 1. NAME OF DECEASED (Type or Print) LOUIS SPIEGEL		69 12351 BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12351	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			2. DATE AND HOUR OF DEATH DECEMBER 12, 1969, 9:15 P.M. 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2003 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 321 S. Pulaski St. 21223 007		
5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-22-96 9. AGE (in years last birthday) 73 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of Armco Co. 10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Louis 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 216-03-0984 17. INFORMANT BCH Records: Baltimore, Md. 21224 ADDRESS 4940 Eastern Ave.		
18. 595X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE SEPSIS DUE TO, OR AS A CONSEQUENCE OF: (B) CHRONIC CYSTITIS DUE TO, OR AS A CONSEQUENCE OF: (C)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Wk. UNKNOWN		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). BILATERAL CEREBROVASCULAR ACCIDENTS		
MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from NOVEMBER 11, 1969 to DECEMBER 12, 1969 that (X) (we) last saw the deceased alive on DECEMBER 12, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael M. McConneal, M.D. 23C. PHYSICIAN'S NAME (Type) Michael M. McConneal M.D.			23B. DATE SIGNED DECEMBER 12, 1969 Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 12-17-69		
24C. NAME OF CEMETERY OR CREMATORY LOUDON PARK			24D. LOCATION (City, town, or county) (State) BALTO. MD.		
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			25B. NAME OF REGISTRAR GEORGE SCHWAB		
25C. FUNERAL DIRECTOR GEORGE SCHWAB			ADDRESS F.H. BALTO. MD.		

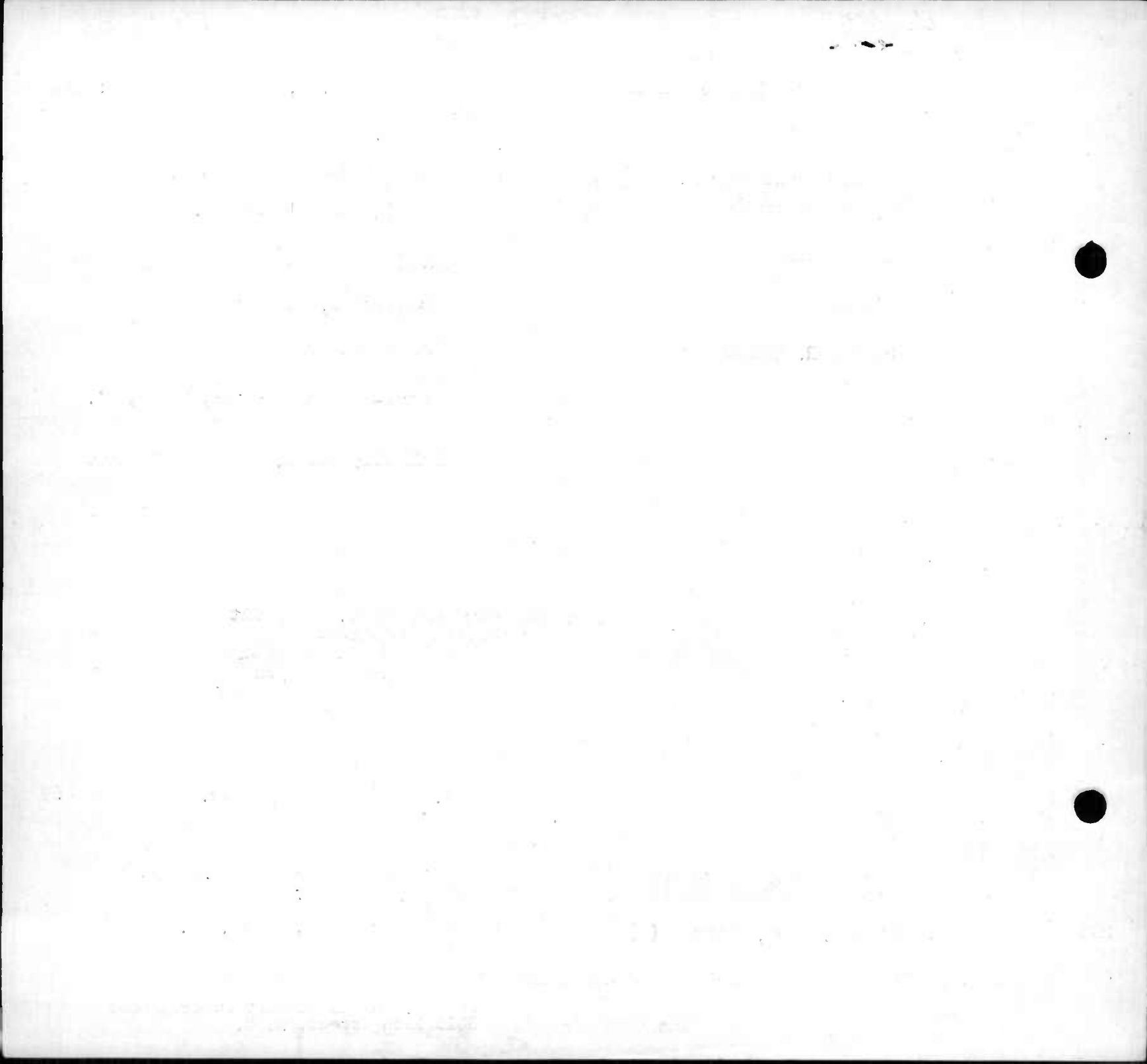


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

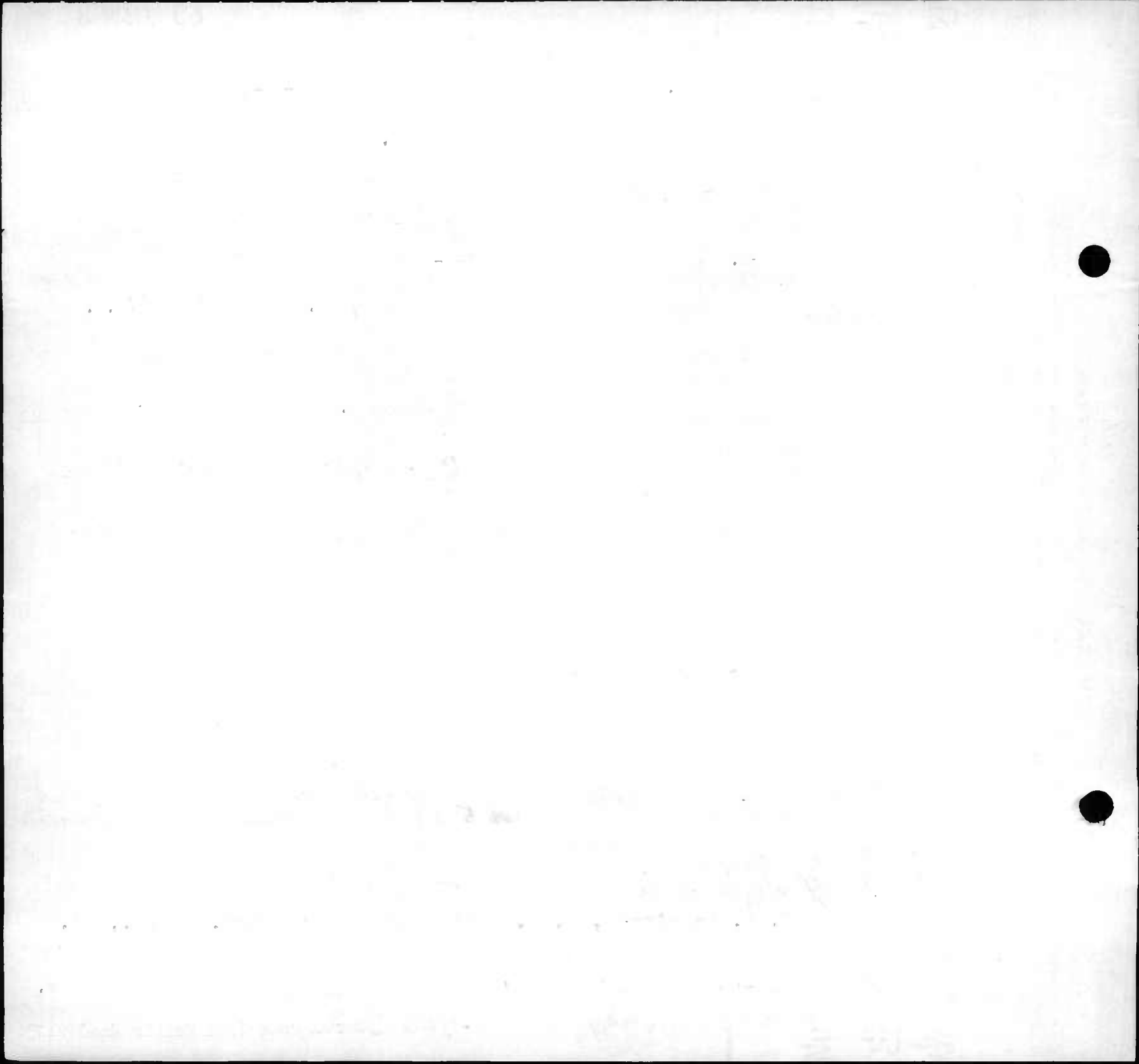
BALTIMORE CITY HEALTH DEPARTMENT									
69 12352 CERTIFICATE OF DEATH					REG. NO. 69 12352				
BIRTH NO. <u>H-452</u>					1. NAME OF DECEASED (Type or Print) Pamela Yvonne Holmes				
2. DATE AND HOUR OF DEATH Dec. 8, 1969					7: 45 P M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Howard				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Public Health Service Hospital 3100 Wyman Parkway					C. CITY OR TOWN Columbia City		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
					E. STREET AND NUMBER 5034 Elliot's Oak Rd.				
5. SEX F	6. RACE col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/5/53	9. AGE (In years last birthday) 16		If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Chester R. Holmes					14. MOTHER'S MAIDEN NAME Gelna Ashford				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.				
18. 450X14/83.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Pulmonary emboli ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Embryonal carcinoma of rt. ovary with abdominal metastases					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					Months				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from Nov. 17 19 69 to Dec. 8 19 69 , that (1) (we) lost saw the deceased alive on Dec. 8 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Samuel P. Ward, M.D.</i> DEGREE					Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED 12/9/69	
23C. PHYSICIAN'S NAME (Type) Smuel P. Ward, Surgeon (R) DEGREE					23D. ADDRESS US PHS Hospital, Balto, Md.				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-12-69		24C. NAME OF CEMETERY OR CREMATORY Lincoln Memorial Cemetery		24D. LOCATION (City, town, or county) (State) Suitland, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			25B. NAME OF REGISTRAR <i>John T. Rhines</i>		25C. FUNERAL DIRECTOR ADDRESS John T. Rhines Company Funeral Home 2015 12th Street, N. E.				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

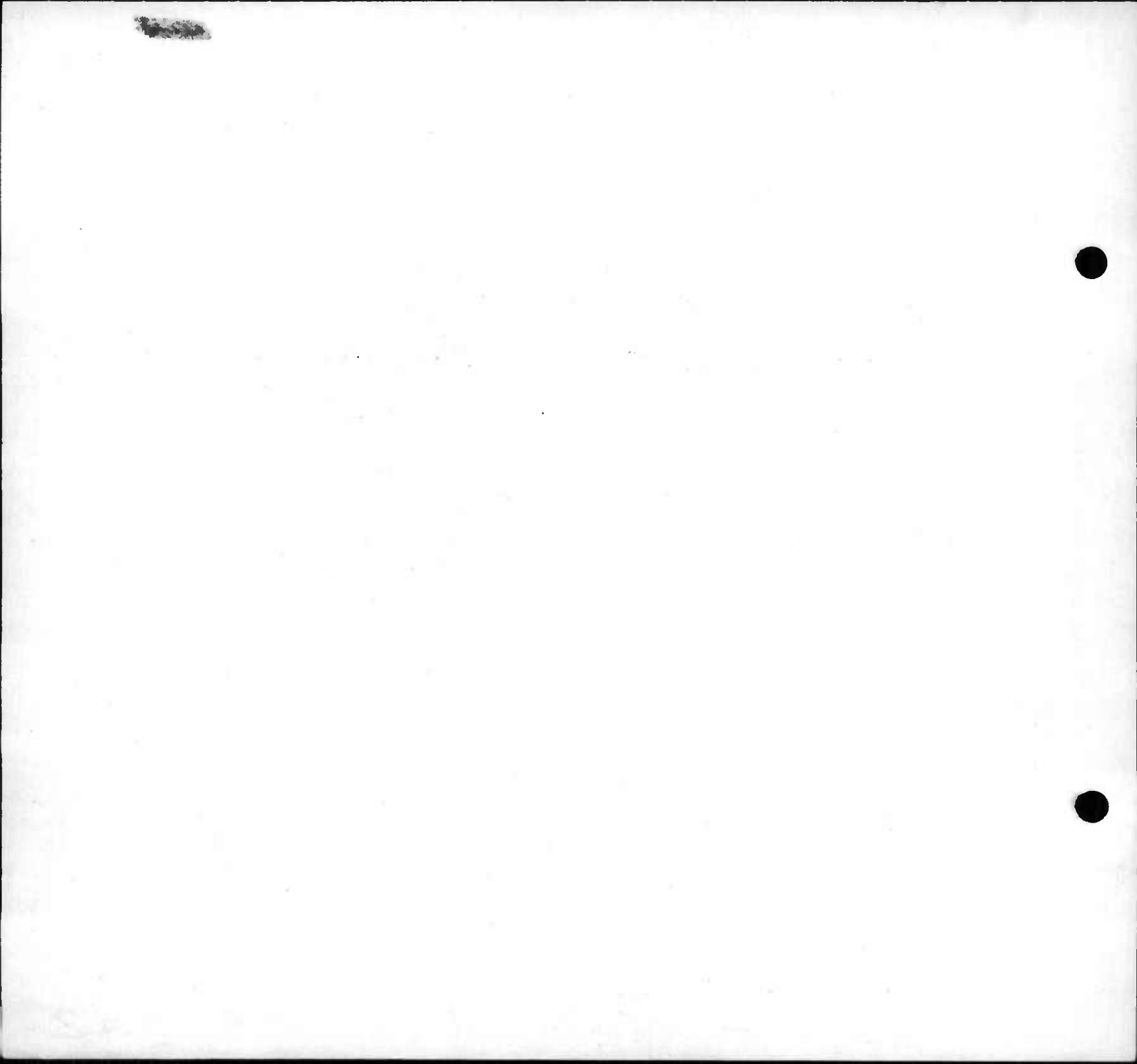
BALTIMORE CITY HEALTH DEPARTMENT				69 12353		REG. NO.	
S-152 69 12353				BIRTH NO.		69 12353	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Marie K. Spangler				12-8-1969			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE		B. COUNTY	
				Md.			
1631 Ingram Road				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1631 Ingram Road 21212			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days	
Female	Cau.	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		2-8-1887	82		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Housewife		Baltimore, Md.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Otto Kaufmann				Wilhelmina Trager			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No						Mrs Gladys J. Callahan 1631 Ingram Road	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				CORONARY THROMBOSIS			
				(B) ARTERIOSCLEROSIS			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) YEAR			
II				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
No				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>Dec 5 1969</u> to <u>Dec 8 1969</u> and that (I) (we) lost saw the deceased alive on <u>Dec 5 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
J. F. Palmisano, M. D.				12-9-69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				6608 Loch Raven Blvd. Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-11-69		Baltimore Nat'l Cemetery		Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 15 1969		Robert E. Taylor		Lassan Funeral Home		7401 Belair Road 21236	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

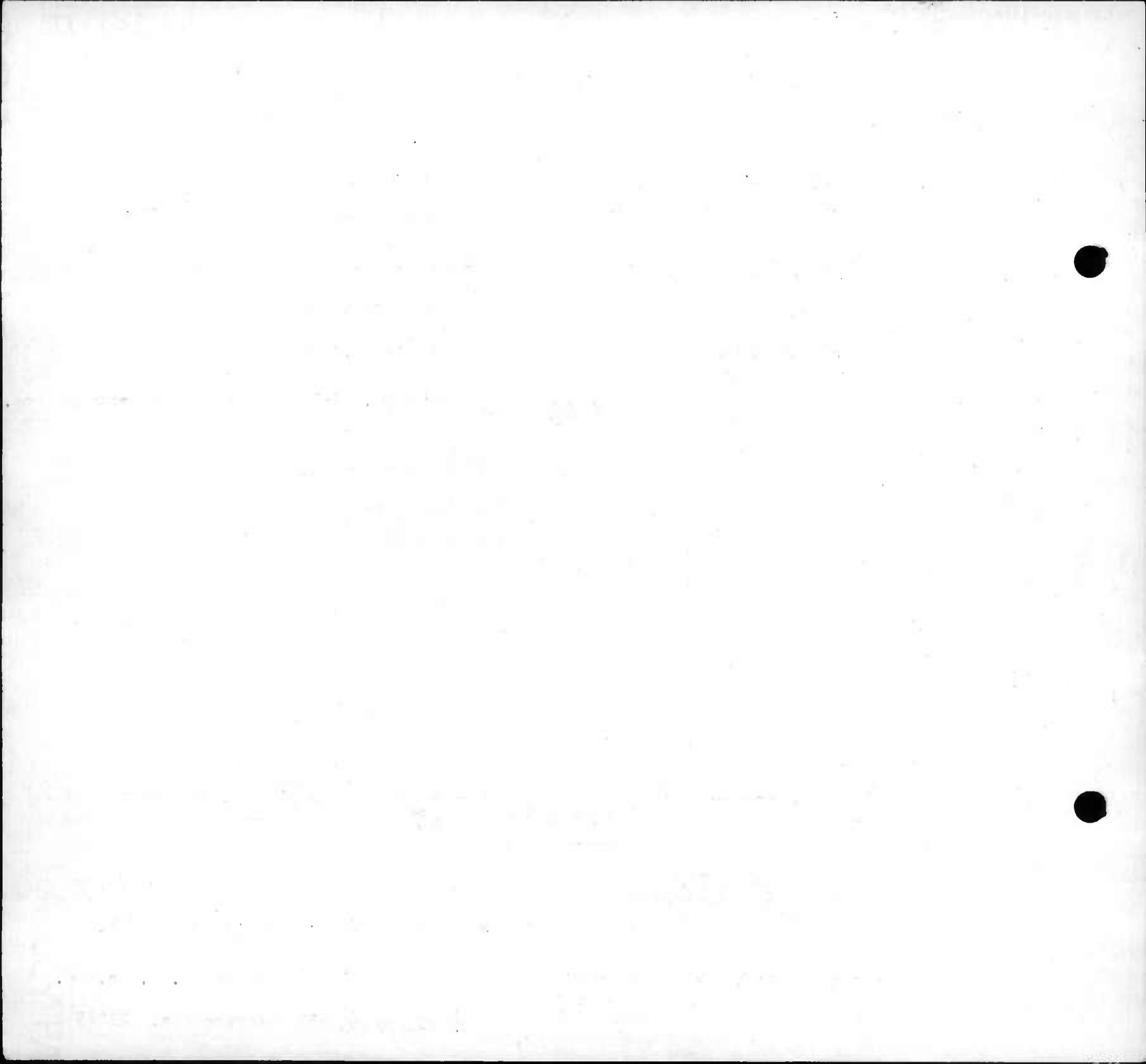
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. [REDACTED] 69 12354	
S-432 69 12354 BIRTH NO. 1. NAME OF DECEASED (Type or Print) Schultz Franklin J.		2. DATE AND HOUR OF DEATH 12-10-69- 2 AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) H Harbor View Ncc		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ind. B. COUNTY 2102 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1566 Ridgely St.			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/9/1885		9. AGE (In years lost birthday) 84
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10B. KIND OF BUSINESS OR INDUSTRY Ind. Steel		11. BIRTHPLACE (State or foreign country) Balt. Ind.	
13. FATHER'S NAME Andrew Schultz		14. MOTHER'S MAIDEN NAME Elizabeth Casey			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-20-6411		17. INFORMANT Irvin Schultz - 1131 Sargent St. (21223)	
18. CAUSE OF DEATH 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Generalized Arterio-sclerotic Cardiovascular Disease with the finale Dementia ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-14 19 69 to 12/10 19 69, that (we) last saw the deceased alive on 12/10 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Diadema Simon Gayag				23B. DATE SIGNED 12/11/69	
23C. PHYSICIAN'S NAME (Type) DIADEMA SIMON GAYAG				23D. ADDRESS 8716 Thornton Rd. Towson, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY OR CREMATORY Green Haven Cem.	
24D. LOCATION (City, town, or county) (State) Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John J. Cowan & Son Inc. 23 Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

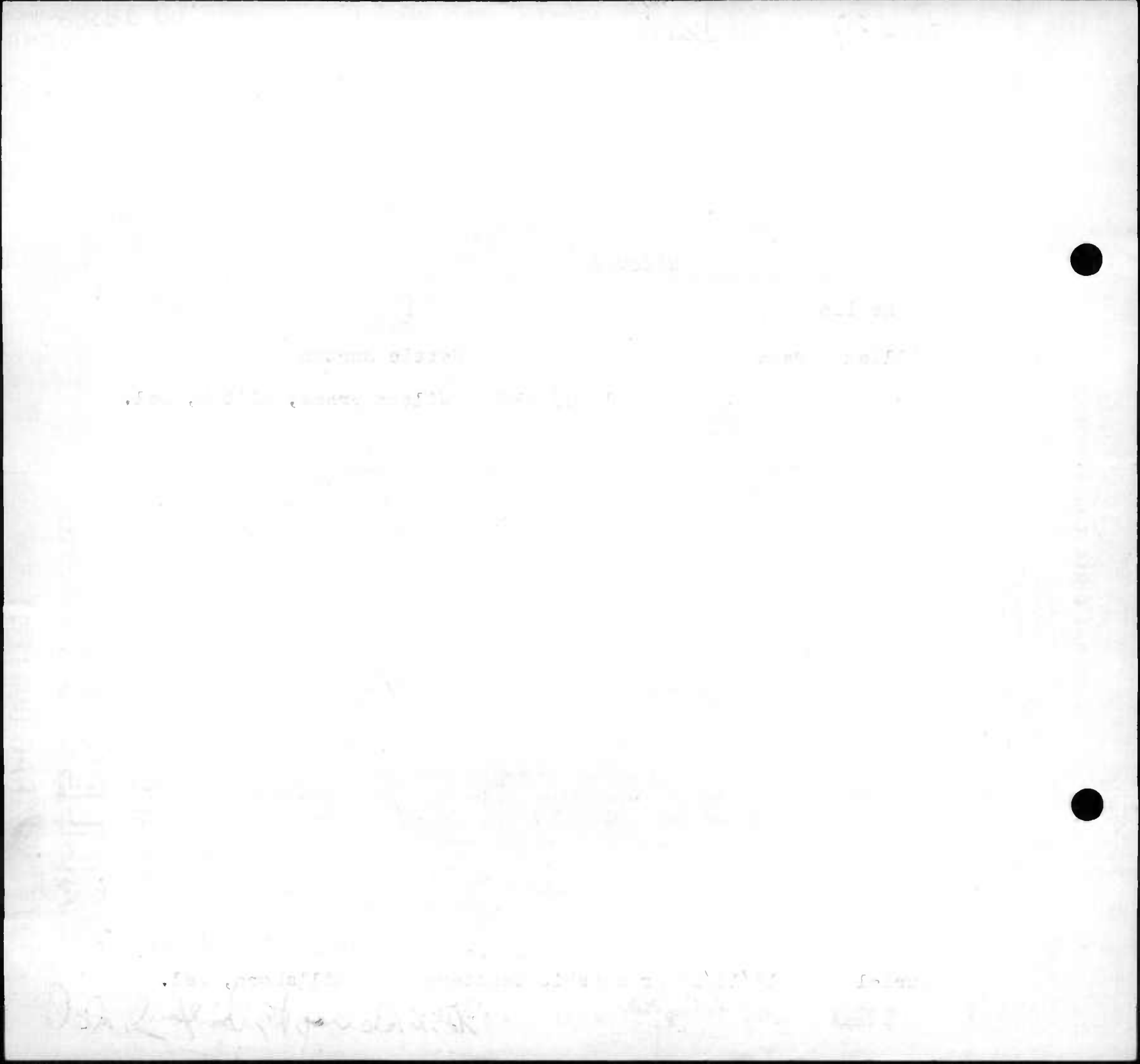
M-235		BALTIMORE CITY HEALTH DEPARTMENT		X	69 12355	
BIRTH NO.		69 12355		CERTIFICATE OF DEATH		REG. NO. 69 12355
1. NAME OF DECEASED (Type or Print) <u>Ethel M. McDonald</u>			2. DATE AND HOUR OF DEATH <u>12-12-69</u> <u>8:00 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Baltimore General Hospital</u> <u>3001 S. Hanover Street</u>			A. STATE <u>MD.</u>		B. COUNTY <u>ANCO.</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>			6. RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		8. DATE OF BIRTH <u>6-11-1899</u>	
13. FATHER'S NAME <u>Michael Hartline</u>			14. MOTHER'S MAIDEN NAME <u>Carrie Viemeyer</u>		9. AGE (In years lost birthday) <u>70</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>215-05-5288</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
17. INFORMANT <u>Sister Mrs. Viola Stecher</u>			ADDRESS <u>3704 West Bay Ave.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>410.0 + 250.9</u> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary occlusion</u> <u>Hypertensive +</u>			<u>minutes</u>
			(B) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF:			<u>10 ± yrs.</u>
			(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			<u>Diabetes mellitus</u>			<u>12 yrs.</u>
19A. DATE OF OPERATION <u>0 none</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>no</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>		
22. I certify that (I) (this hospital) attended the deceased from <u>1-21-1957</u> to <u>12-12-1969</u> , that (I) (we) last saw the deceased alive on <u>11-29-1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.						
23A. SIGNATURE <u>C. C. CHIU M.D.</u>					23B. DATE SIGNED <u>12-13-69</u>	
23C. PHYSICIAN'S NAME (Type) <u>C. C. CHIU M.D.</u>					23D. ADDRESS <u>1 E. Randall St. (21230)</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/16/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u>		24D. LOCATION (City, town, or county) (State) <u>Ritchie Highway A. A. Co. Md.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>McAleer</u>		
				ADDRESS <u>237 Patapsco Ave. 21225</u>		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

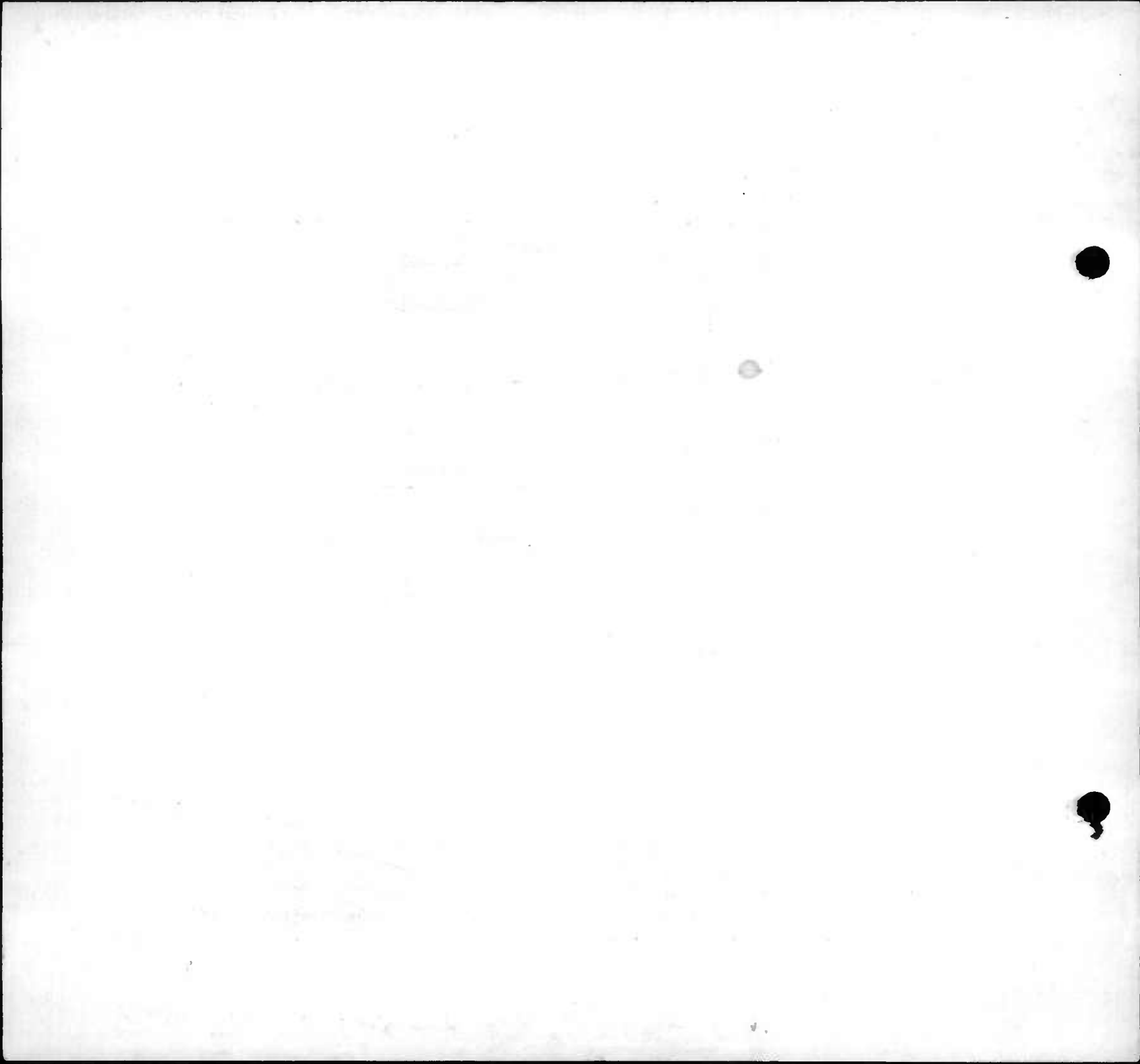
BIRTH NO. 69 12356		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12356	
M.E. CASE NO.		CERTIFICATE OF DEATH		RAINES	
1. NAME OF DECEASED (Type or Print) Catherine Raines		2. DATE AND HOUR OF DEATH 12/7/69 7:30 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Maryland General Hosp		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 1701			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto			
		D. STREET ADDRESS (If rural, give location) 576 St. Marys St.			
5. SEX F	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2/14/1893	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Del.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Frame		14. MOTHER'S MAIDEN NAME Hattie Burton	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219 05 0384		17. INFORMANT ADDRESS Wilson Frame, Milton, Del.	
18. 430.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO CVA (subarachnoid hemorrhage) (B) DUE TO Cardiac arrhythmia (C) _____		INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/7/69 to 12/7/69 and that (I) (we) lost saw the deceased alive on 12/7/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael J. [Signature]				23B. DATE SIGNED 12/7/69	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/69		24C. NAME OF CEMETERY or CREMATORY Friendship Cemetery	
				24D. LOCATION (City, town, or county) (State) Millsboro, Del.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR [Signature]	
				ADDRESS [Signature]	



FUNERAL DIRECTOR: IMPORTANT

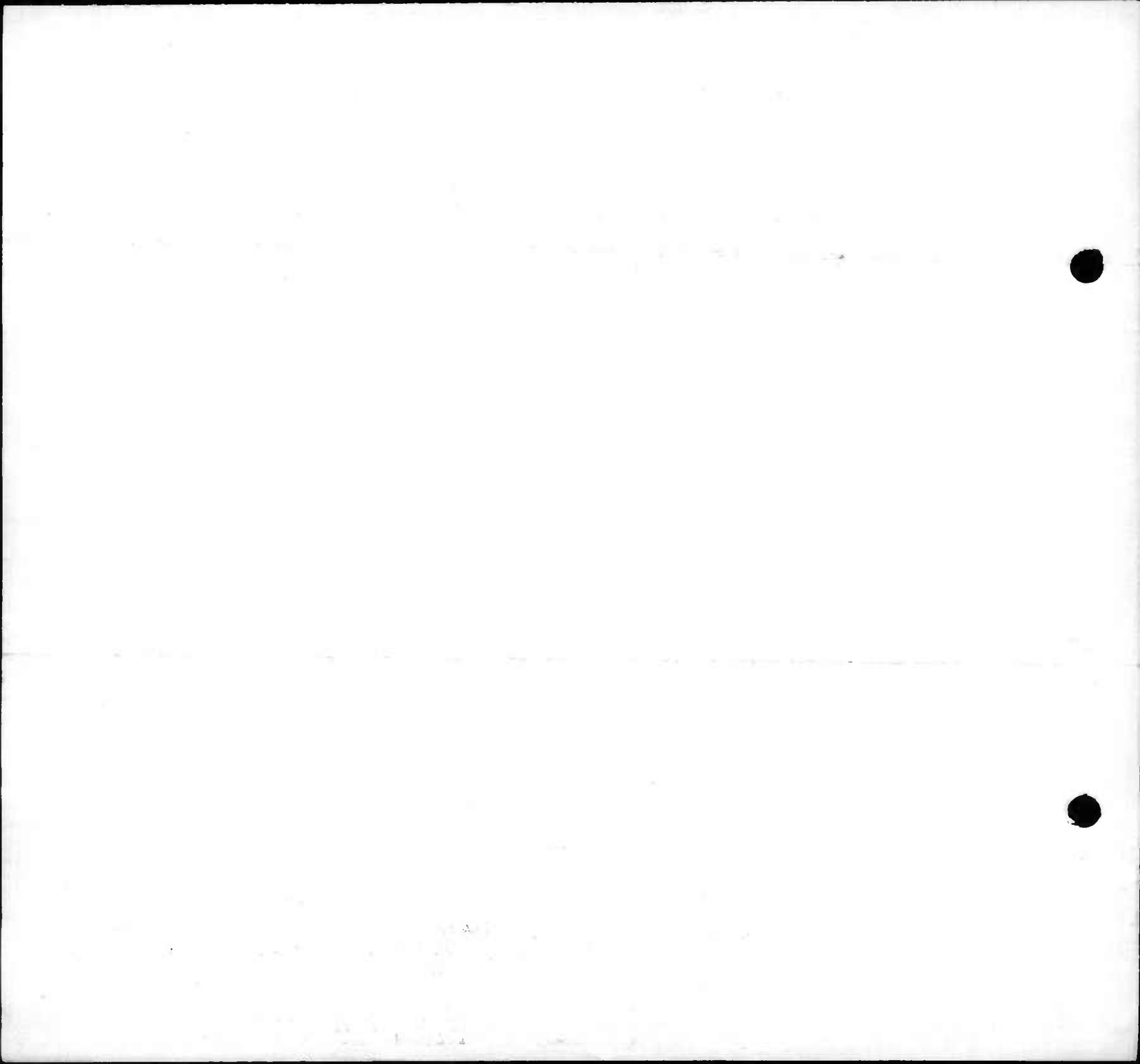
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-630 69 12357		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12357	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FRANK BARTA			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH NOVEMBER 30, 1969 4:17 P.M.			
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2612			
5. SEX Male		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 76	
13. FATHER'S NAME Frank		14. MOTHER'S MAIDEN NAME Ina		11. BIRTHPLACE (State or foreign country) Czechoslovakia	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. INFORMANT 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 011.34571.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PROBABLE ACTIVE PULMONARY TB DUE TO, OR AS A CONSEQUENCE OF Malignant melanoma Left eye (enucleated) DUE TO, OR AS A CONSEQUENCE OF Adenocarcinoma of colon DUE TO, OR AS A CONSEQUENCE OF Chronic obstructive lung disease, haemorrhagic pneumonia DUE TO, OR AS A CONSEQUENCE OF UNKNOWN			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from NOVEMBER 19, 1968 to NOVEMBER 30, 1969 , that (1) (we) lost saw the deceased alive on NOVEMBER 29, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael M. McConnell M.D.		23B. DATE SIGNED NOVEMBER 30, 1969		23C. PHYSICIAN'S NAME (Type) Michael Mc Connell M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-11-69		24C. NAME OF CEMETERY or CREMATORY JOHNS HOPKINS MEDICAL SCHOOL	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCHD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-652		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	69 12358
69 12358		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ARMACOST, WILHEMINA		11-29-69 11:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
MONTZEBELLO STATE HOSPITAL		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 1803	
91 BALTIMORE, Md. 21218		E. STREET AND NUMBER		1115 S. POPPLETON AVE ST	
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
F	W		12-30-1900	68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 43391 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Cerebro-vascular accident (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Probably cerebral artery thrombosis (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
N/O					
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 26 1969 to Nov. 29 1969 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
K. P. Tan		11-29-69			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
KIAO-SIONG TAN, M.D.		ANATOMY BOARD OF MARYLAND BALTIMORE, MD, 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
		12-5-69			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 15 1969		Robert E. Gabley, M.D.		MORTUARY SERVICE - BCHD	



69 12359

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12359

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <u>JOSEPH HARRINGTON</u>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>11</u> Day <u>15</u> Year <u>69</u> Hour <u>9:40 a.m.</u>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>38 University Hospital</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month <u>November</u> Day <u>15</u> Year <u>1969</u> Hour <u>9:40 a.m.</u>			
6. SEX <u>Male</u> 7. RACE <u>Negro</u>				5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1802</u>			
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
9. DATE OF BIRTH		10. AGE (In years last birthday) <u>18</u>		E. STREET AND NUMBER <u>306 Arlington Ave.</u>			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME							
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				17. SOCIAL SECURITY NO.			
18. INFORMANT				ADDRESS			
19. <u>486X1</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonia</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
20A. DATE OF OPERATION <u>2</u>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <u>YES</u>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?							
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22F. HOW DID INJURY OCCUR?							
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Isidore Mihalakis, M.D.</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Isidore Mihalakis, M.D.</u> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>11/16/69</u> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>							
24A. BURIAL (CREMATION, REMOVAL) (Specify)				24B. DATE <u>12.9.69</u>			
24C. NAME OF CEMETERY or CREMATORY <u>Baltimore University Medical School</u>				24D. LOCATION (City, town, county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>				25B. NAME OF REGISTRAR <u>Robert E. Jones, M.D.</u>			
25C. FUNERAL DIRECTOR				ADDRESS			
HOSPITAL DISPOSAL							

[Handwritten signature]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12360

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

SAMUEL SHERIFF

2. DATE OF DEATH Known ☒ Month Day Year Hour
Estimated ☐ 11 14 69 ? M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

38 University Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
November 14, 1969 ? M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE South Carolina B. COUNTY V-37

6. SEX

Male

7. RACE

Negro

B. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Manning

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

10. AGE (In years lost birthday)

49

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Craniocerebral injuries
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☒ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)

St. Rt. 213 (Road)

22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?

St. Rte. 213 near Galena, Md.

22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY (APPROX.) ? ? ? 69 m.

22E. INJURY OCCURRED

WHILE AT
WORK ☐NOT WHILE
AT WORK ☒

22F. HOW DID INJURY OCCUR?

Unknown

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Tsodore Mihalakis, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11/16/69

24A. BURIAL (CREMATION,
REMOVAL (Specify)

24B. DATE

12/9/69

24C. NAME OF CEMETERY OR CREMATORY

24D. LOCATION (City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 15 1969

Robert E. Taylor, M.D.

ANATOMY BOARD OF MARYLAND

UNIVERSITY MEDICAL SCHOOL

HOSPITAL DISPOSAL

Letter from M.E.'s office

2-25-70 M.H.

RECEIVED
FEB 26 1970
FBI

ALBERTA
VALLEY FOL
252-444-1111
1970

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12361	
G-320 69 12361				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		X <u>Wanda Gowdeski</u>		<u>November 23 1969</u> <u>1:30</u> PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Union Memorial Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1205</u>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN <u>Baltimore City</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>325 E. North Avenue</u>		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
<u>Female</u>	<u>White</u>		<u>1-04-91</u>	<u>78</u>	<u>U.S.</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				<u>MARYLAND</u>	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
<u>Unknown</u>					
18. <u>450X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH ✓ <u>Multiple Pulmonary Embolism with pulmonary infarction</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>yes</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
<u>3</u>		<u>Acute Abdomen</u>		<input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that the (this hospital) attended the deceased from <u>10/30</u> 19 <u>67</u> to <u>23</u> 19 <u>69</u> , that it (we) last saw the deceased alive on <u>11/23</u> 19 <u>69</u> and that in the (our) opinion death occurred on the date and hour and from the causes stated above. It (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>David S. Schwartz</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
				<u>Union Memorial Hospital</u>	
24A. BURIAL (CREMATION, REMOVAL (Specify))		24B. DATE		24C. NAME OF CEMETERY	
		<u>12.8.69</u>		<u>Richmond</u>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. ADDRESS	
<u>DEC 15 1969</u>		<u>Robert E. [illegible]</u>			

ANATOMY BOARD OF MARYLAND
UNIVERSITY MEDICAL SCHOOL
HOSPITAL DISPOSAL

12/16/69 - Date of operation
11/18/69

operation performed for
ac. abd - lysis of
adhesions
tra phone - lumen Mem.

X

1-00-01
18

5-2-2

APR 21

1

69 12362

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12362

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

JOHN

SULLIVAN

2. DATE
OF
DEATHKnown ☐ Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL
OR INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)3. DATE
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

November 7, 1969

5:39 P.

5. USUAL RESIDENCE (Where deceased lived. If Institution: residence before admission)

A. STATE

Maryland

B. COUNTY

203

6. SEX

Male

7. RACE

White

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

9. DATE OF BIRTH

10. AGE (In years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

730 S. Broadway

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF
WHAT COUNTRY?

13. FATHER'S NAME

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)17. SOCIAL
SECURITY NO.

18. INFORMANT

ADDRESS

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS
UNDERLYING ☐ OR CONTRIB-
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)
OF INJURY
(APPROX.)

22E. INJURY OCCURRED

WHILE AT
m. WORK ☐NOT WHILE
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATUREEXAMINER'S
NAME (Type)

Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

11-8-69

24A. BURIAL (CREMATION)
REMOVAL (Specify)

24B. DATE

12.9.69

24C. NAME OF CEMETERY

24D. LOCATION (City, town, & county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

DEC 15 1969

Robert E. Gubay, M.D.

0 0 0 9

HOSPITAL DISPOSAL

ARMADILLO BOMB

VALLEY PARK 10 00

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-600		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12363	
BIRTH NO. 69 12363		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>John Henry Gray</u>			2. DATE AND HOUR OF DEATH <u>12/11/69</u> <u>5¹⁵pm</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>Lincoln Memorial Nursing Home</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1802</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>27n Carey Street</u>		
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/6/1896</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-01-3329 MB</u>		17. INFORMANT ADDRESS <u>Mrs Catherine Gray-1701 E-25th</u>	
18. <u>410.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Coronary Thrombosis</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1-23-69</u> 19 to <u>12-11</u> 19 <u>69</u> , that (I) (we) lost saw the deceased alive on <u>12-11</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>12-11-69</u>		
23C. PHYSICIAN'S NAME (Type) <u>[Signature]</u>			23D. ADDRESS <u>[Signature]</u>		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12/3/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Wt. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) <u>Balt. Md.</u>		24E. (State) <u>Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>	
25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>		25D. ADDRESS <u>[Signature]</u>	

8/12

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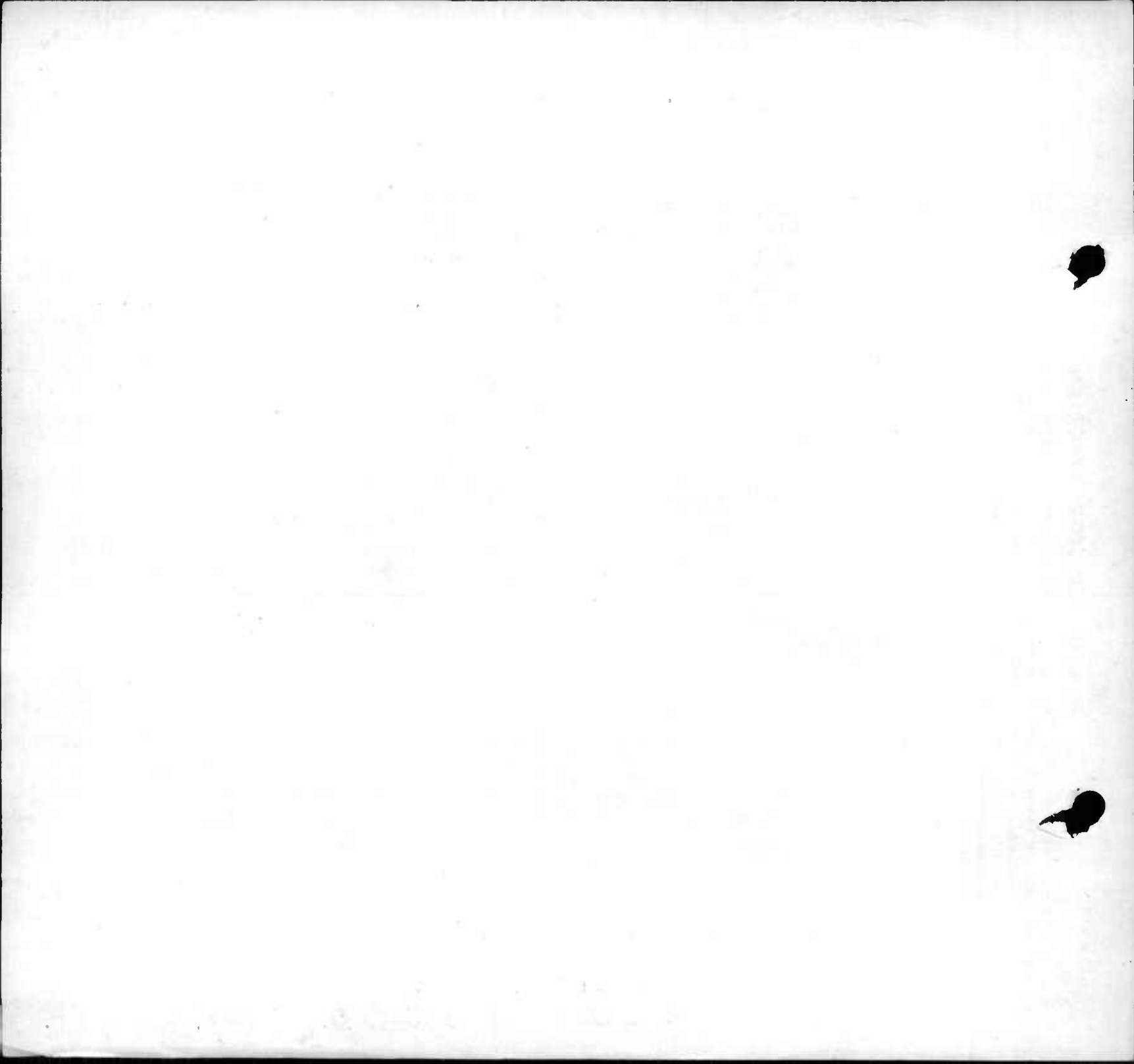
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12364</u>
BIRTH NO. <u>69 12364</u>		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <u>Ernest H. Brown Sr.</u>		2. DATE AND HOUR OF DEATH <u>12-10-69</u> <u>6:30 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1204 Oakhurst Place</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1607</u> C. CITY OR TOWN <u>Balto.</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1204 Oakhurst Pl.</u>		
5. SEX <u>Male</u>	6. RACE <u>Negroid</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-17-00</u>	9. AGE (In years lost birthday) <u>69</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Va.</u>
13. FATHER'S NAME <u>Julius Brown</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Bailey</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ernest Brown Jr.</u> ADDRESS <u>same</u>
MEDICAL CERTIFICATION 18. <u>582 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>NOV 20</u> 19 <u>69</u> to <u>DEC 10</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>DEC 10</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>[Signature]</u> 23C. PHYSICIAN'S NAME (Type) <u>E. L. BANFIELD, MD</u> 23D. ADDRESS <u>722 N. Fulton Ave, BALT.</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> 24B. DATE <u>12-21-69</u> 24C. NAME OF CEMETERY or CREMATORY <u>Cape Charles Cemetery</u> 24D. LOCATION (City, town, or county) (State) <u>Cape Charles, Virginia</u> 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1969</u> 25B. NAME OF REGISTRAR <u>[Signature]</u> 25C. FUNERAL DIRECTOR <u>V. Bailey</u> ADDRESS <u>1348 N. Calhoun St.</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>URÆMIA</u> (B) CHRONIC RENAL DISEASE DUE TO, OR AS A CONSEQUENCE OF: <u>Von Recklinghausen's Disease</u> (C)		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12365

BIRTH NO. 69-21105

1. NAME OF DECEASED
(Type or Print)

Quincy Young

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF DECEASED (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

00 3509 Milford St. 1-26-70

3. DATE PRONOUNCED DEAD Month Day Year Hour 12 13 69 11:15 a.m.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2802

6. SEX

male

7. RACE

colored

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

11-15-69

10. AGE (In years last birthday)

11. Under 1 Yr. 12 Under 24 Hrs. Months Days Hours Min. 28

E. STREET AND NUMBER

3509 Milford St.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF

U.S.A.

13. FATHER'S NAME

Frederick Young

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Rose Reid

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no

17. SOCIAL SECURITY NO.

18. INFORMANT

Frederick Young

ADDRESS

same

19.

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

Bronchopneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(A) IMMEDIATE CAUSE (SDII) - Interstitial pneumonia DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

22E. INJURY OCCURRED

WHILE AT WORK ☐NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

Deputy Chief Medical Examiner

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

12/14/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-16-69

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION (City, town, or county) (State)

Balto. Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR V. Bailey ADDRESS

Nelson F.R. 1348 Calhoun St.

ACADEMY BOND

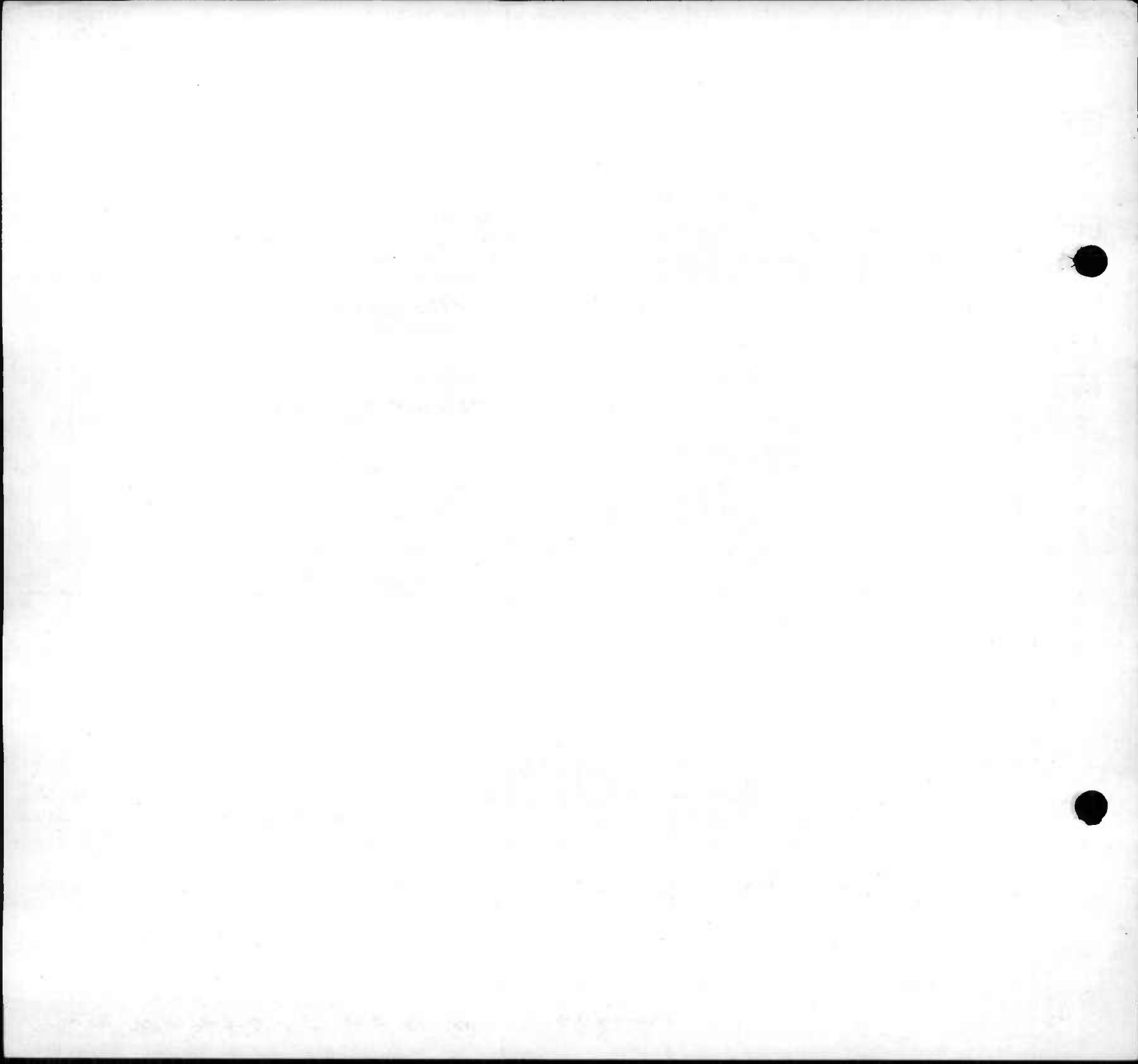
100% CONTENT

VALLEY PAPER CO.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12366
BIRTH NO. 69 12366		CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) ESTELLA STERLING		2. DATE AND HOUR OF DEATH DEC. 11, 1969		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2130 N. BRUNT STREET		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 1403 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2130 BRUNT STREET		
5. SEX FEMALE	6. RACE NEGROID	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1 194	9. AGE (In years last birthday) 75
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ADDISON STERLING		
14. MOTHER'S MAIDEN NAME SAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.		17. INFORMANT		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH 412.21 Cerebral Hemorrhage ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Hypertensive Cardio-Vascular Disease (B) DUE TO, OR AS A CONSEQUENCE OF: Disease (C) ...		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 5 yr		
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 12-11 1969 to 12-11 1969 that (I) (we) last saw the deceased alive on 12-11 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE G. Franklin Phillips M.D.			23B. DATE SIGNED 12/13/69	
23C. PHYSICIAN'S NAME (Type) G. Franklin Phillips M.D.			23D. ADDRESS 558 Mc Mechen St Balto, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-13-69		24C. NAME OF CEMETERY OR CREMATORY MT. AUBURN CEM.
24D. LOCATION (City, town, or county) (State) BALTO., MD.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		
25B. NAME OF REGISTRAR R. B. Bailey		25C. FUNERAL DIRECTOR R. B. Bailey, F.D.		
25D. ADDRESS 1348 N. CALHOUN STREET				



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 12367 CERTIFICATE OF DEATH

REG. NO. 69 12367

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

SHARPE, MARTHA B.

2. DATE AND HOUR OF DEATH

DECEMBER 13 1969 8:45AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST AGNES HOSPITAL
CATON & WILKENS AVENUE
BALTIMORE MARYLAND 21229

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE MARYLAND

B. COUNTY

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

16 S ABBINGTON AVENUE 21229

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

09/25/85

9. AGE (In years last birthday)

84

10. Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

NORTH CAROLINA

12. CITIZEN OF WHAT COUNTRY?

U S A

13. FATHER'S NAME

ANDREW BANKS

14. MOTHER'S MAIDEN NAME

ALEXZINER JONES

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

213 54 0116

17. INFORMANT

Pencie Bunch 16 S Abington
ST AGNES HOSP CATON & WILKENS AVE

18.

412.4 I
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

CAUSE OF DEATH

[This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Broncho-Pneumonia

(B)

DUE TO, OR AS A CONSEQUENCE OF:

A-S-C-V-D.

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/05/69 19 to 12/13/69 19 that (I) (we) last saw the deceased alive on 12/13/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (X) (not) view the body after death.

23A. SIGNATURE

ABDOLLAH SHAMS MD

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

12-13-69

23C. PHYSICIAN'S NAME (Type)

ABDOLLAH SHAMS MD

23D. ADDRESS

ST AGNES HOSP BALTO MD 21229

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12-17-69

24C. NAME OF CEMETERY OR CREMATORY

Arbutus Mem. Park

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, MD

25C. FUNERAL DIRECTOR

V.R. Bailey Kelson E.H. 1348 Calhoun Street

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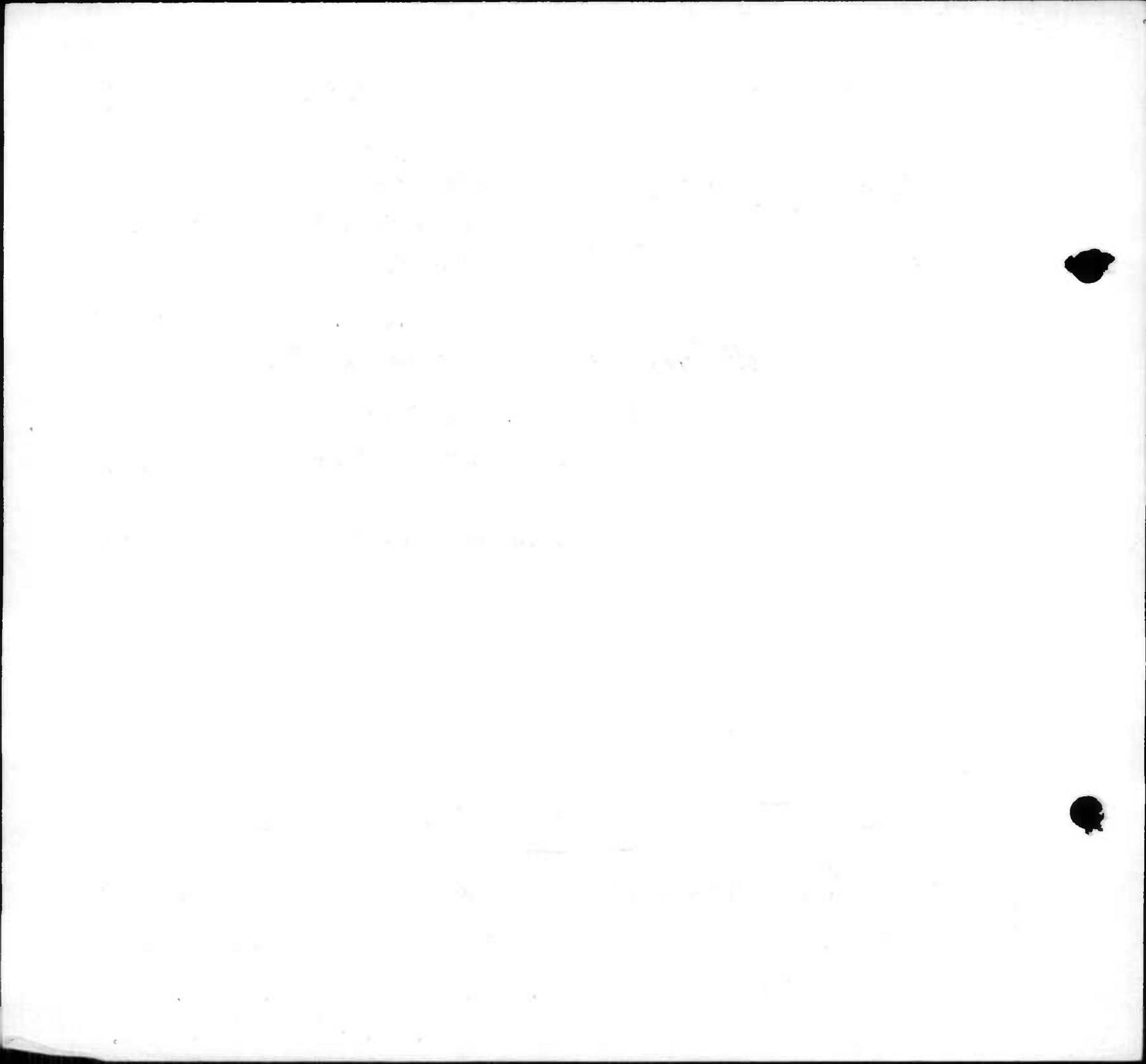
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

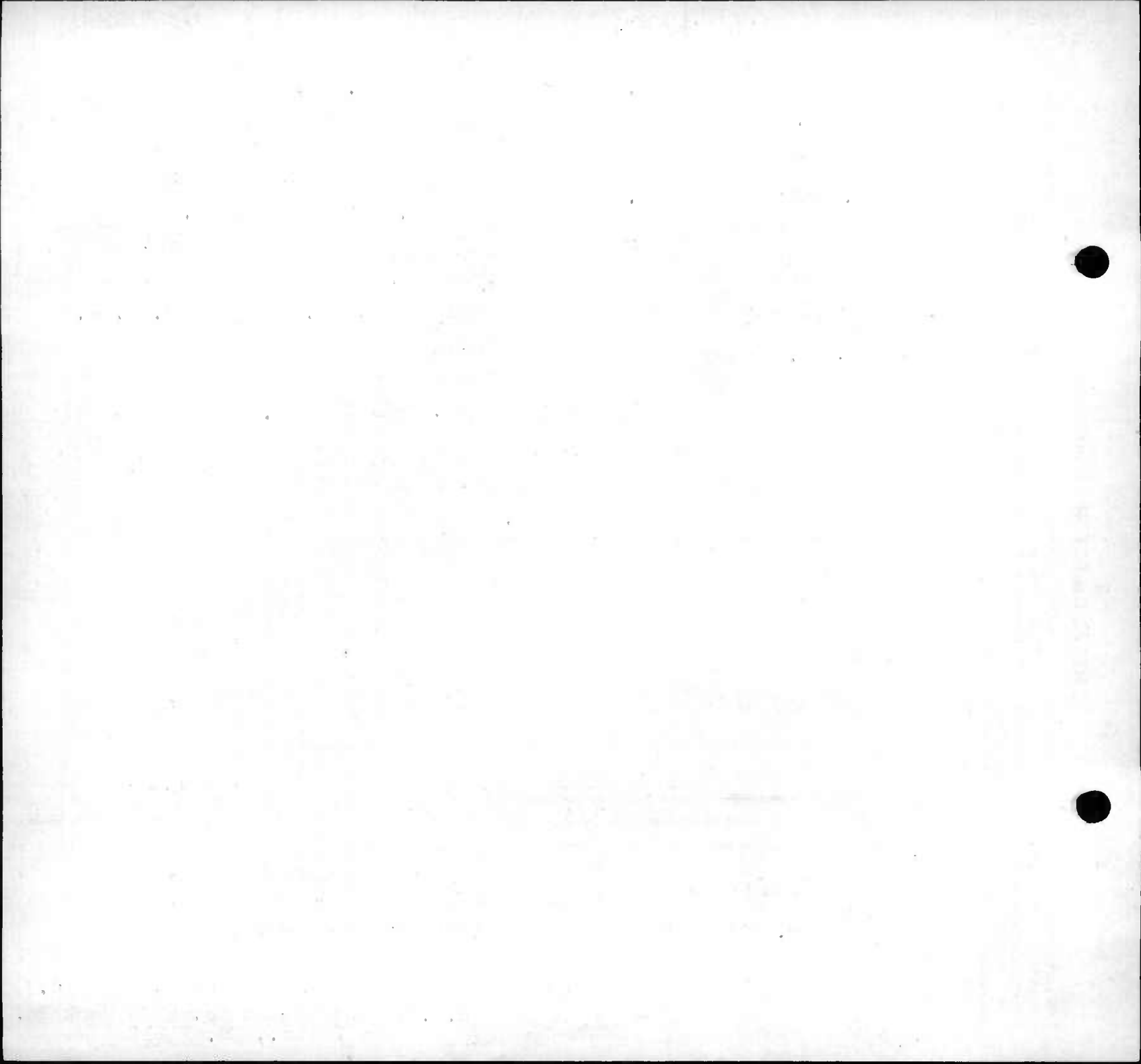
BIRTH NO.		69 12368		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12368	
1. NAME OF DECEASED (Type or Print) <u>MARGO E. Smith</u>				2. DATE AND HOUR OF DEATH <u>12/12/69</u> <u>11 23</u> P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>PROVIDENT HOSPITAL</u> <u>1514 DIVISION STREET</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1538</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2716 W. GARRISON BLVD</u>					
5. SEX <u>F</u>	6. RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/26/41</u>	9. AGE (in years last birthday) <u>28</u>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Balto., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM WASHINGTON</u>				14. MOTHER'S MAIDEN NAME <u>MARION COUNTER</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>220-36-0001</u>		17. INFORMANT <u>Lewis Smith</u>		ADDRESS <u>2716 Garrison Ave.</u>	
18. <u>637.9 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>TOXEMIA OF PREGNANCY</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARDIAC ARREST</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 HRS.</u> <u>2 HRS.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> - Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>SEPT 19 69</u> to <u>DEC 12, 19 69</u> that (I) (we) last saw the deceased alive on <u>DEC 12, 19 69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>N. Alan Harris, M.D.</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>12/13/69</u>			
23C. PHYSICIAN'S NAME (Type) <u>N. ALAN HARRIS, M.D.</u>				23D. ADDRESS <u>4200 EDMONDSON AVE. 21229</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-16-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>		25C. FUNERAL DIRECTOR <u>V. Bailey</u>		ADDRESS <u>Kelson T.H. 1348 Calhoun St.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12369	
<div style="display: flex; justify-content: space-between;"> 69 12369 CERTIFICATE OF DEATH </div>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Charles A. Dorsey		Dec. 12, 1969 6³⁰ P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION 901 W. University Pkwy.			A. STATE Maryland		
			B. COUNTY		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 901 W. University Pkwy.		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/31/1902	9. AGE (In years last birthday) 67
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Safety Engineer		10B. KIND OF BUSINESS OR INDUSTRY Insurance		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Charles A. Dorsey		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 215-03-7810		17. INFORMANT Mrs. Nell Clough Dorsey	
				ADDRESS (Same)	
18. 395.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH <i>Rheumatic Heart disease</i> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>stroke</i> (B) _____ DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>yr</i>		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1959</i> to <i>12/12/69</i> that (I) (we) lost saw the deceased alive on <i>12/5</i> 19 <i>1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE <i>Milton Kirsh</i>				23B. DATE SIGNED <i>12/13/69</i>	
23C. PHYSICIAN'S NAME (Type) Dr. Milton Kirsh				23D. ADDRESS 4000 Northern Parkway	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY OR CREMATORY Woodlawn	
				24D. LOCATION (City, town, or county) (State) Baltimore County, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR <i>Robert E. Barber, R.D.</i>		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto., Md. 21212	



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FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT

69 12370

CERTIFICATE OF DEATH

REG. NO.

69 12370

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Gustav G Siegel

2. DATE AND HOUR OF DEATH

Dec 12, 1969 1:39P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

Union Memorial Hospital

H4

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)
A. STATE B. COUNTY

Md.

C. CITY OR TOWN

Baltimore 21218

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

3711 Delverne Rd.

5. SEX

M

6. RACE

W

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

2/11/02

9. AGE (in years
last birthday)

67

If Under 1 Yr.

Months

Days

If Under 24 Hrs.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

CONSTRUCTION

10B. KIND OF BUSINESS OR INDUSTRY

ARUNDEL CORP.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Gustav Siegel

14. MOTHER'S MAIDEN NAME

Marie W. Kommalan

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL
SECURITY NO.

215-09-1730

17. INFORMANT

MRS. CLARA M. SIEGEL (SAME)

ADDRESS

18. 450X I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (1) (this hospital) attended the deceased from 11/21 1969 to 12/12 1969
that (1) (we) last saw the deceased alive on Dec 11 1969 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Alan B Cohen MD

DEGREE

Attending ☒Med.
Director ☐Staff
Phys. ☐

23B. DATE SIGNED

12/12/69

23C. PHYSICIAN'S
NAME (Type)

Dr. Alan B. Cohen

DEGREE

23D. ADDRESS

3501 ST Paul ST 21218

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/16/69

24C. NAME OF CEMETERY OR CREMATORY

Loudon Park

24D. LOCATION

Baltimore

(City, town, or county)

(State)

Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

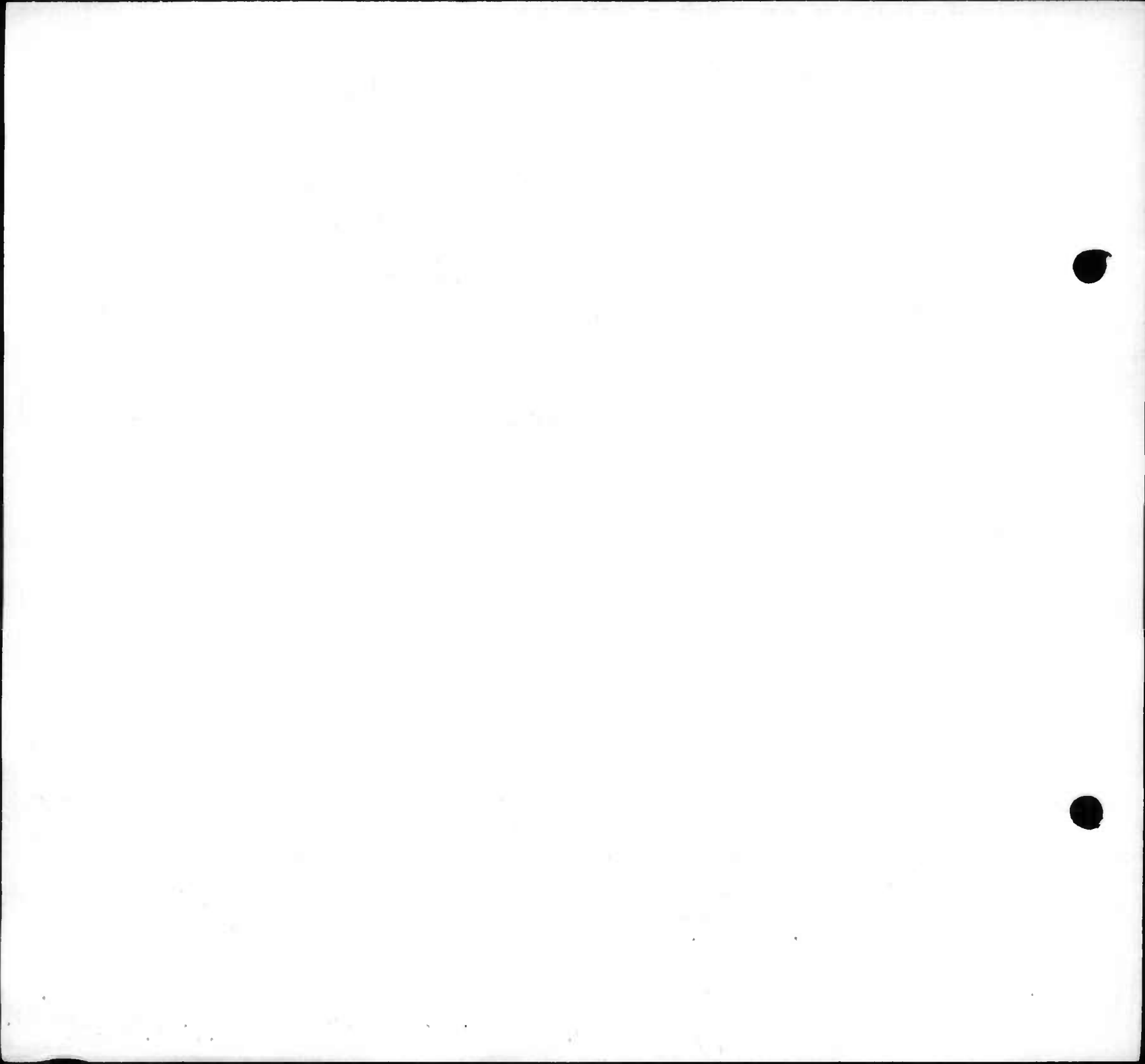
25B. NAME OF REGISTRAR

Phyllis E. Farber, M.D.

25C. FUNERAL DIRECTOR

H. W. Jenkins & Sons Co. 1905 York Rd.
Balto., Md. 21212

ADDRESS



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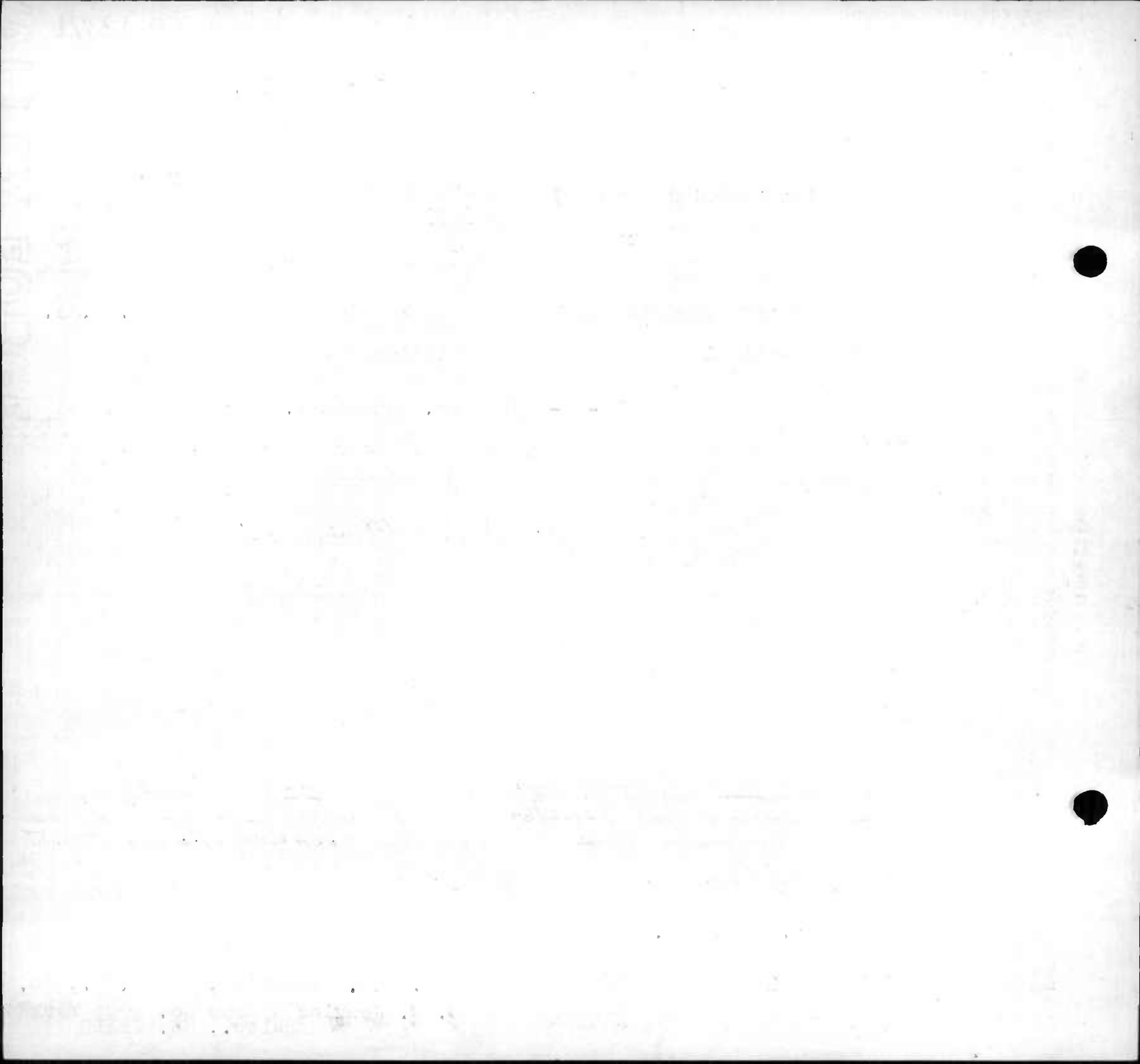
FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT
69 12371 CERTIFICATE OF DEATH

REG. NO. 69 12371

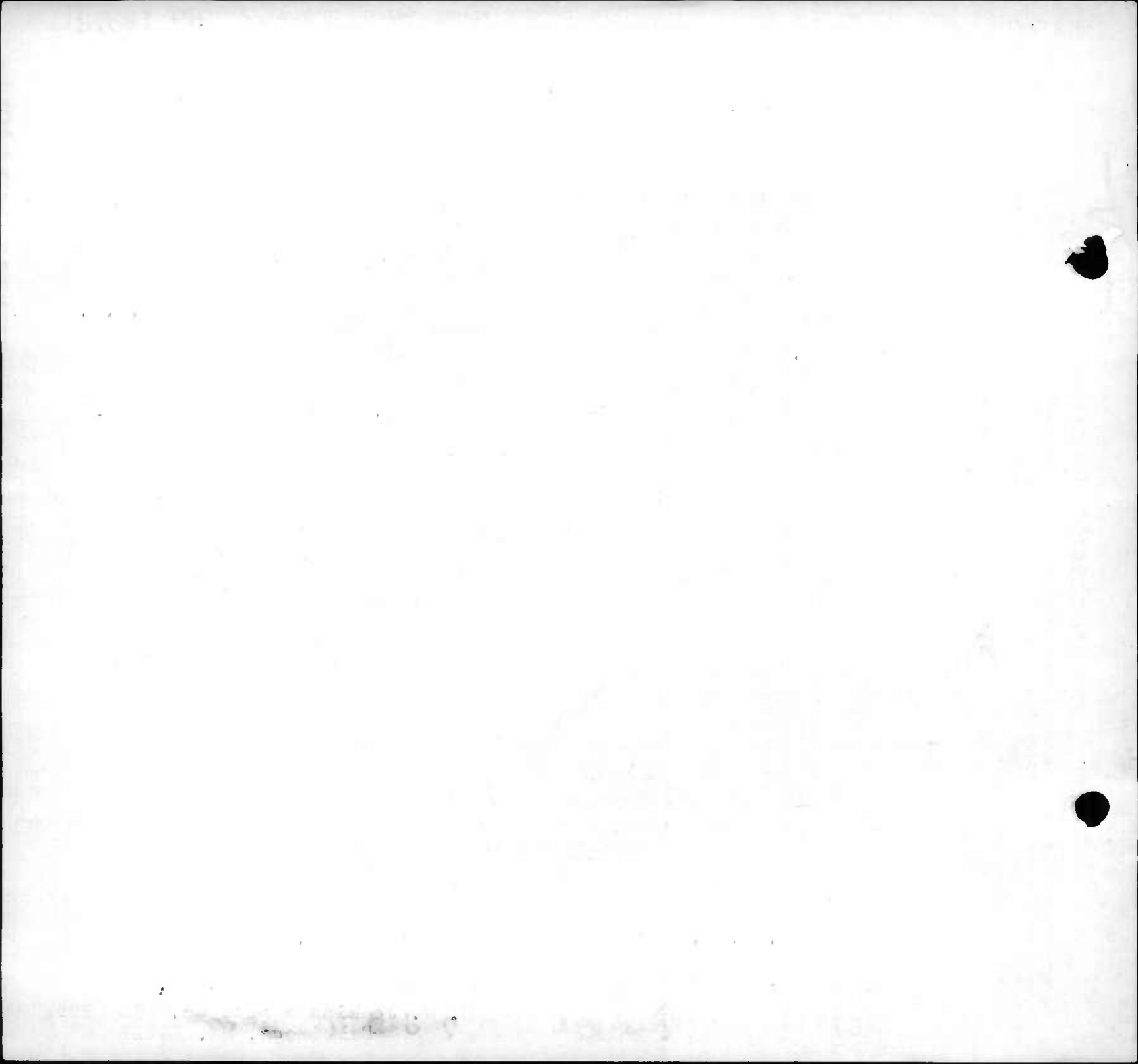
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		William Percy Dashiell		December 12, 1969 3:00 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY	
44 Union Memorial Hospital				Maryland	
				C. CITY OR TOWN	
				Baltimore 21218	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3833 Kimble Road	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH (lost birthday)	9. AGE (In years)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
M	W		6/25/1893	76	Retired Engineer
		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
		Westinghouse	Maryland		U. S. A.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Thaddies Dashiell			Lillian Riffin		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
Yes		WWI		Mrs. Cynthia D. Dashiell (Same)	
		215-09-8756			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.3 I		Coronary Heart Disease		3 yrs	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) Generalized Arteriosclerosis			
		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1952 to 12/12/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. DOA Union Memorial Hosp. Md.					
23A. SIGNATURE				23B. DATE SIGNED	
Thomas L. Worsley				12/15/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Thomas L. Worsley				6505 York Road	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12/15/69		Dulaney Valley Mem. Grds.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
DEC 15 1969		R. E. Fisher, Md.		H. W. Jenkins & Sons Co. 1905 York Rd. Balto., Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

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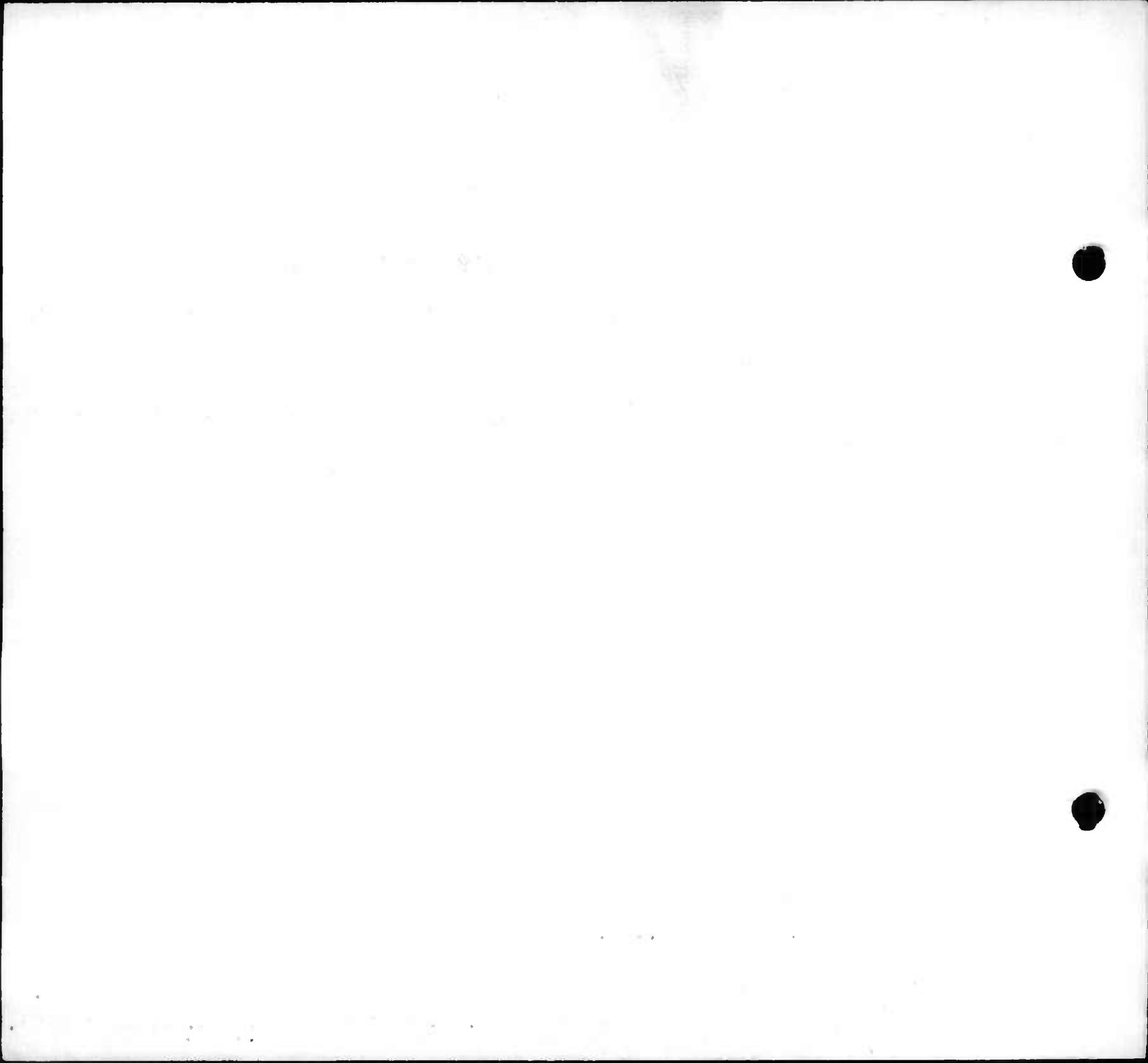
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12372	
BIRTH NO. 69 12372		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Frances Louise Schoenewolf		2. DATE AND HOUR OF DEATH 12 - 13 - 1969 1:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence admission) A. STATE Maryland B. COUNTY 2712 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 311 Broadmoor Road			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/1883	9. AGE (In years last birthday) 86	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Frank L. Camm		14. MOTHER'S MAIDEN NAME Louisa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-01-7454B		17. INFORMANT John C. Schoenewolf	
18. 402 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 0		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Congestive Heart Failure Advanced Myocardial Disease Hypertension (B) Advanced Arterio-sclerosis DUE TO, OR AS A CONSEQUENCE OF: (C).....		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs Gradual onset 411	
MEDICAL CERTIFICATION 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Oct 1943 to 12-13 1969, that (I) (we) last saw the deceased alive on 12-12-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. W. H. Woody		23B. DATE SIGNED 12-14-69		23C. PHYSICIAN'S NAME (Type) Dr. W. H. Woody	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 12/16/69		24C. NAME OF CEMETERY or CREMATORY Loudon Park Mausoleum	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Rd Baltimore, Md. 21212	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12373		REG. NO. 69 12373	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Robert Early Baden (doctor)</u>				2. DATE AND HOUR OF DEATH <u>11 Dec 69</u> <u>1150 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1307</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>				C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>505 W. University Pkwy.</u>			
5. SEX <u>M</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>09-09-75</u>	9. AGE in years (last birthday) <u>94</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dentist</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Teeth</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>(American) U.S.A</u>
13. FATHER'S NAME <u>Robert E. Baden</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Thomas</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>213-48-6810</u>		17. INFORMANT <u>(Hospital Clerk) KATHERINE D. BADEN</u> ADDRESS <u>(SAME)</u>		
18. <u>519.1 I</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>Acute pulmonary edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <u>(D.H.)</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>12-08</u> 19 <u>69</u> to <u>12-11</u> 19 <u>69</u> that (1) (we) last saw the deceased alive on <u>12-11</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>M. Cepale M.D.</u>				23B. DATE SIGNED <u>11 Dec 69</u>		23C. PHYSICIAN'S NAME (Type) <u>M. Cepale, M.. D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>				24B. DATE <u>12/15/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenmount</u>	
24D. LOCATION <u>Baltimore</u>				24E. ADDRESS <u>Union Memorial Hosp.</u>		24F. ADDRESS <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>				25B. NAME OF REGISTRAR <u>Robert E. Label, M.D.</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins & Sons Co.</u>	
				25D. ADDRESS <u>4905 York Rd. Balto., Md.</u>		25E. ADDRESS <u>212</u>	



69 12374

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12374

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Pauline McDonald		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 12 69 1:55 p. m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 814 Dartmouth Rd.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 12 69 1:55 p. m.	
6. SEX female		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2768	
9. DATE OF BIRTH Sept. 6, 1929		10. AGE (in years last birthday) 40	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harold G. Smithson		14. MOTHER'S MAIDEN NAME Lillian L. Larrimore	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper		16. KIND OF BUSINESS OR INDUSTRY State of Md.	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		18. SOCIAL SECURITY NO. 213-28-6619	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Overdose of barbiturates ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. Due to, or as a consequence of:		20. DATE OF OPERATION 12 12 69	
21. CONDITION FOR WHICH OPERATION WAS PERFORMED Partial		22. AUTOPSY? (Yes or No) Partial	
23. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		24. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
25. TIME (Month) (Day) (Year) (Hour) (Approx.) 12 12 69 ? m.		26. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 814 Dartmouth Rd. 2768	
27. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		28. HOW DID INJURY OCCUR? ingested overdose of pills	
29. I certify that held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		30. ACTUAL SIGNATURE Werner U. Spitz, M.D.	
31. NAME (Type) Werner U. Spitz, M.D.		32. DATE SIGNED 12/13/69	
33. BURIAL CREMATION, REMOVAL (Specify) Burial		34. DATE 12/16/69	
35. NAME OF CEMETERY or CREMATORY Poplar Grove		36. LOCATION (City, town, or county) (State) Cockeysville, Balto Co., Md.	
37. DATE REC'D BY HEALTH DEPT. DEC 15 1969		38. NAME OF REGISTRAR Robert E. Farber, M.D.	
39. FUNERAL DIRECTOR H. W. Jenkins & Sons Co.		40. ADDRESS 4905 York Rd Balto., Md. 21212	

10-15-11

F-635

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

69 12375

BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

REG. NO.

69 12375

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

FORTINO.

JOSEPH A

JOSEPH A

2. DATE AND HOUR OF DEATH

12-12-69

9:30

p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

433rd Street Balto Md 21218

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

8

2636

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4434 FORESTVIEW AVE

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

07-28-04

9. AGE (In years
last birthday)

65

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

None Retired

10B. KIND OF BUSINESS OR INDUSTRY

STEEL CO.

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF WHAT COUNTRY?

AMERICAN

13. FATHER'S NAME

UNKNOWN DOMINIC FORTINO

14. MOTHER'S MAIDEN NAME

UNKNOWN ROSE GRIMALDI

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

UNKNOWN

None

16. SOCIAL
SECURITY NO.

213-07-8883

17. INFORMANT

Mrs. Antoinette Fortino. See above

ADDRESS

18. 571.81

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE
DUE TO, OR AS A CONSEQUENCE OF:

Liver failure

(B) Biliary syndrome

(C) probably postoperative anastomosis

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

He was in coma since 11/23/69

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF
DEATH (notify medical examiner)

No

21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/23/69 to 12/12/69.
that (I) (we) last saw the deceased alive on 12/12/69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

D. P. van Kammen

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/12-69

23C. PHYSICIAN'S
NAME (Type)

D. P. VAN KAMMEN

23D. ADDRESS

UNION MEMORIAL HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

BURIAL

24B. DATE

12-15-69

24C. NAME OF CEMETERY OR CREMATORY

Meadow Rose Cemetery

24D. LOCATION

(City, town, or county)

(State)

Washington Blvd. Dorsey Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

25B. NAME OF REGISTRAR

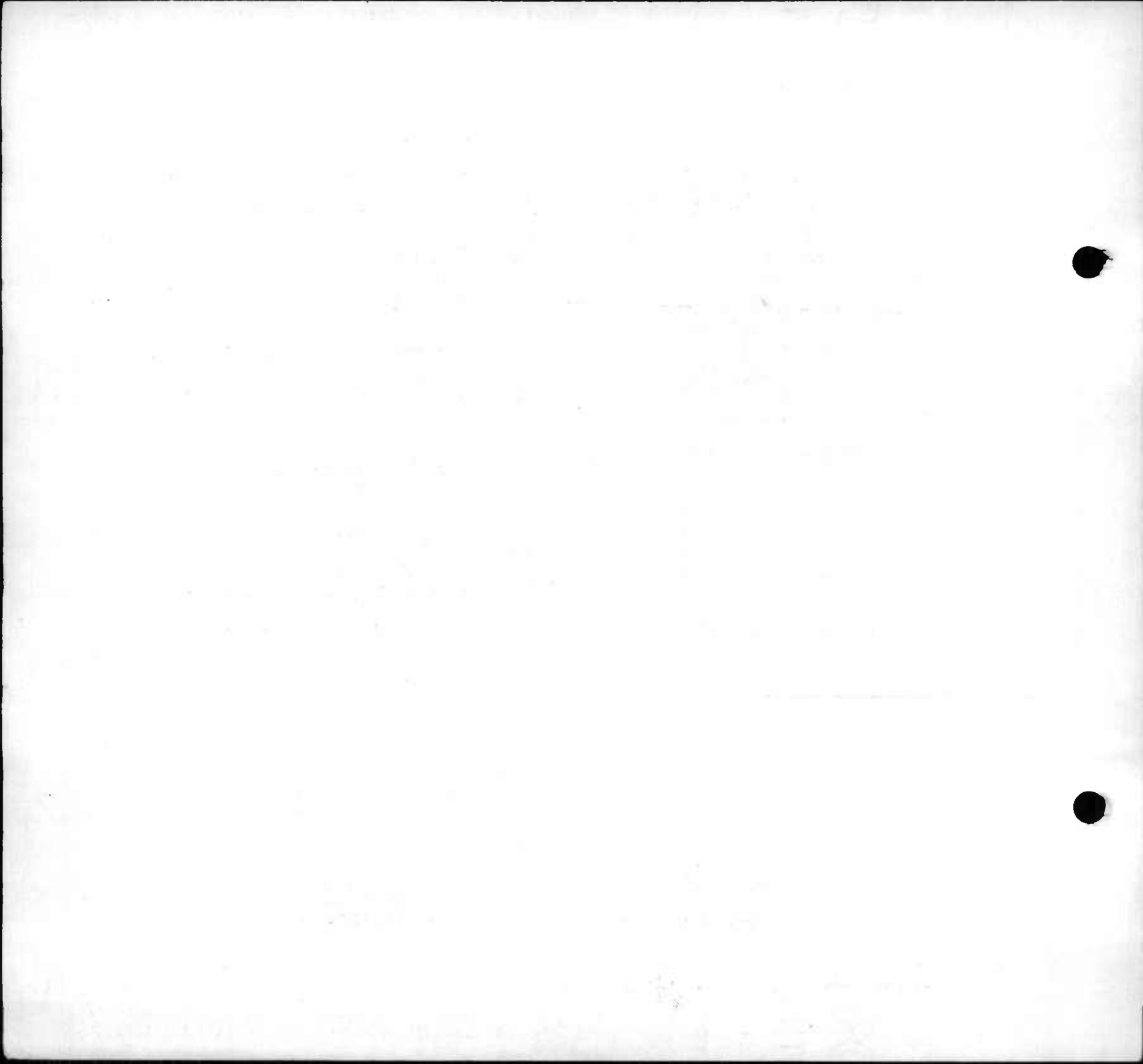
R. E. Taylor

25C. FUNERAL DIRECTOR

Dipper Bros Inc 7110 Benard Rd

ADDRESS

21206



1
T-250

BALTIMORE CITY HEALTH DEPARTMENT

69 12376 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12376

BIRTH NO.

1. NAME OF DECEASED (Type or Print) FAIRELLE (FAIR E.) TYSON		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 12 Day 12 Year 69 Hour 3:50 a.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Balto. General Hospital		3. DATE PRONOUNCED DEAD Month 12 Day 12 Year 1969 Hour 3:50 a.m.	
6. SEX Female		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 806	
7. RACE Negro		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER 1822 N. Castle St.	
9. DATE OF BIRTH 9-25-17		10. AGE (In years last birthday) 52	
11. BIRTHPLACE (State or foreign country) Greenville, N. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ernest Moore		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic	
15. MOTHER'S MAIDEN NAME ? Jordon		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT 1822 N. Castle St ADDRESS 21213 Leroy Tyson	

MEDICAL CERTIFICATION	19. CAUSE OF DEATH E812.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
	(A) IMMEDIATE CAUSE Pulmonary embolism, massive secondary to phlebothrombosis of the lower extremities and pelvis due to recent auto accident.			
	(B) secondary to phlebothrombosis of the lower extremities and pelvis due to recent auto accident.			
	(C) auto accident.			
	20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
	21. AUTOPSY? (Yes or No) YES			
	22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street Intersection, Potee St. & Patapsco Ave.	
	22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) 11 24 69 9:15a	
	22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject passenger in auto-auto coll.	
	23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/12/69		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-16-69		
24C. NAME OF CEMETERY or CREMATORY Carver Memorial Park		24D. LOCATION (City, town, or county) (State) Laurel, Maryland		
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		
25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213		Marshall W. Jones, Jr.		

Auto accident
12/17/69 - Injury to pelvis
Information via phone
w/ed Exam Office in Michalakio
gc

Letter from M.E.'s office
4-2-70 M.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12377	
B-650 69 12377				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		JAMES BROWN JR.		2. DATE AND HOUR OF DEATH 12-10-69 9:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION THE JOHNS HOPKINS HOSPITAL 303		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND 909	
		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1827 N. HOPE ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-18-27	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) N.C.	
13. FATHER'S NAME JAMES BROWN		14. MOTHER'S MAIDEN NAME MELISSA WILLIAMS		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 246-24-7687		17. INFORMANT Thelma Scott 221 N. Fremont Ave	
18. 431.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH PROBABLE INTRACEREBRAL HEMORRHAGE (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) CEREBROVASCULAR, DIABETES (C) MELLITUS, HYPERTENSION II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). HYPERTENSION, DIABETES MELL.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-8-69 19 to 12-10-69 19, that (I) (we) last saw the deceased alive on approx 6:00 P.M. 12-10-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. SYLVESTER				23B. DATE SIGNED 12-10-69	
23C. PHYSICIAN'S NAME (Type) J. SYLVESTER				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cems	
24D. LOCATION Baltimore Md.		24E. NAME OF REGISTRAR Robert E. Taylor		24F. FUNERAL DIRECTOR Wm. March	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR 928 E. North Ave	

ST 92
MAY 22 1964

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12378

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Martha Pleasant		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1718 Light St.		3. DATE PRONOUNCED DEAD Month 12 Day 13 Year 69		Hour 8:00 a.		M.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2303							
6. SEX female	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH March 10, 1888	10. AGE (In years last birthday) 81	11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 1718 Light St.	
13. FATHER'S NAME unknown		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker					
15. MOTHER'S MAIDEN NAME unknown		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no					
17. SOCIAL SECURITY NO. 217-07-70350		18. INFORMANT ADDRESS Family records					
19. 412.41 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20A. DATE OF OPERATION 12/16/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. DATE SIGNED 12/13/69 EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/69		24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR John Burns		25C. FUNERAL DIRECTOR John Burns Sons		ADDRESS Towson Maryland	

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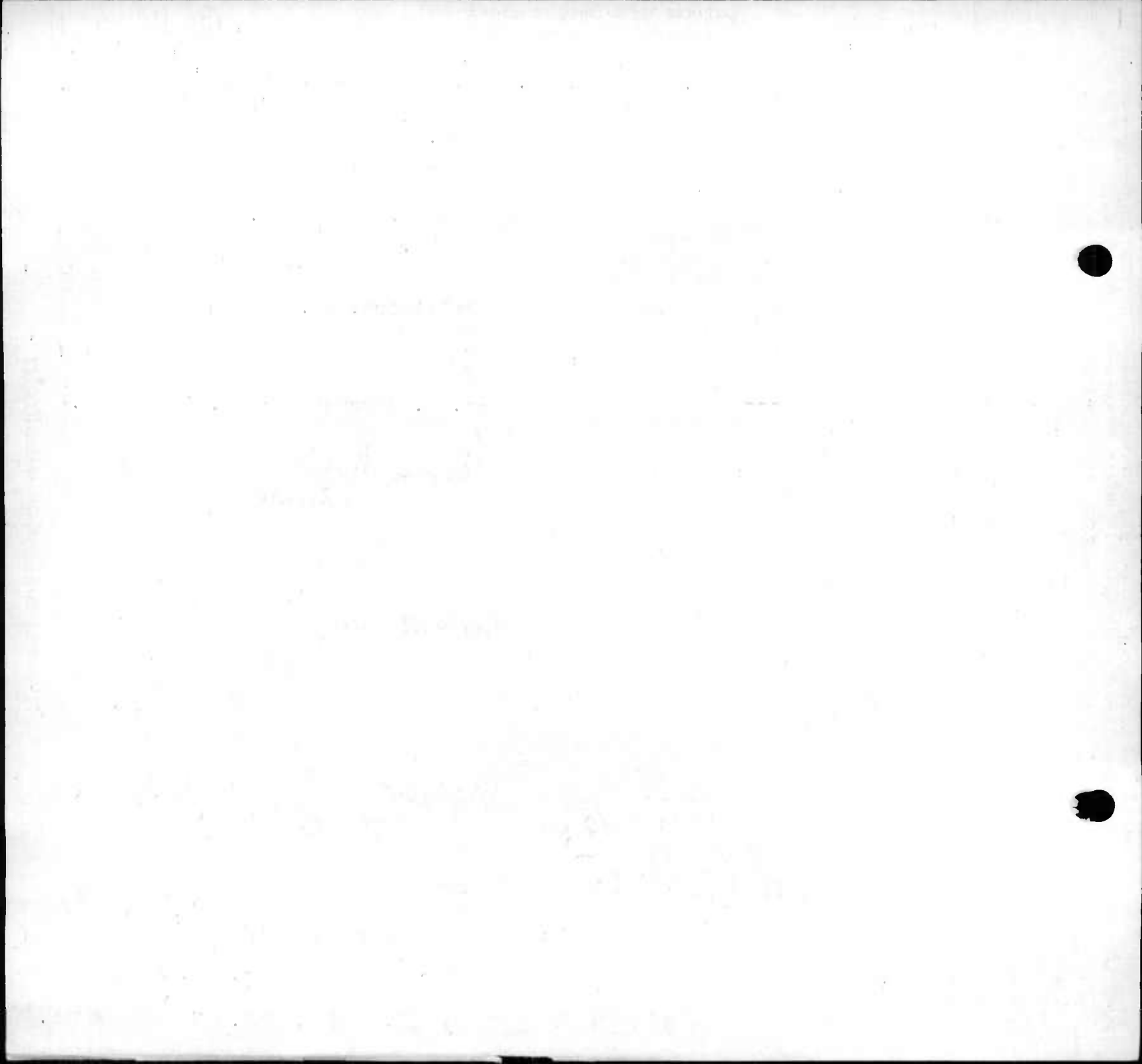
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12379	
B-230 69 12379				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) William L. Bouchat, Sr.		2. DATE AND HOUR OF DEATH December 11, 1969 6 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1001		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION 716 E. Biddle St.		E. STREET AND NUMBER 716 E. Biddle St.			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/189	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body Builder		10B. KIND OF BUSINESS OR INDUSTRY Truck		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unk		14. MOTHER'S MAIDEN NAME Unk	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Geo. L. Bouchat	
				ADDRESS 716 E. Biddle St.	
18. 205.1 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Chronic Myelo-myelogenous Leukemia		2	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		General arteriosclerosis			
19A. DATE OF OPERATION 0	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8/10/1944 19 to 12/11/69 19, that (I) (we) last saw the deceased alive on 12/8/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Samuel Legum MD		23B. DATE SIGNED 12-11-69		23C. PHYSICIAN'S NAME (Type) SAMUEL LEGUM MD	
23D. ADDRESS Medical Arts Bldg - 101 W. Ward		23E. DATE REC'D BY HEALTH DEPT. DEC 15 1969			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore, Md.		24E. NAME OF REGISTRAR John F. DeB...			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR John F. DeB...		25C. FUNERAL DIRECTOR JOHN F. DEB...	
				ADDRESS 715 Light St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-220		69 12380		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. [REDACTED]	
BIRTH NO.				69 12380			
1. NAME OF DECEASED (Type or Print) <i>Guzik; Rosalie</i>				2. DATE AND HOUR OF DEATH <i>12/11/69 4:30 AM</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>md.</i> B. COUNTY <i>1403</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Park Hill Convalescent Home 1802 Euterpe</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>Female</i>		6. RACE <i>Caucasian</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 1874-95 yrs.</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>[REDACTED]</i>	
13. FATHER'S NAME <i>P</i>				14. MOTHER'S MAIDEN NAME <i>Czyrinska P</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>24-56-734</i>		17. INFORMANT <i>Admission Record - Park Hill Reg Home</i>	
18. <i>436.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <i>Cerebro-vascular accident</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>several yrs.</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>no</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Dec. 19 68</i> to <i>12-11-69</i> 19 <i>69</i> , that (I) (we) lost saw the deceased alive on <i>12-9</i> 19 <i>69</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>E. Ellsworth Cook</i>				23B. DATE SIGNED <i>12-12-69</i>			
23C. PHYSICIAN'S NAME (Type) <i>Dr. E. Cook</i>				23D. ADDRESS <i>2431 Maryland Ave. Balto., Md. 21218</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/13/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Cross Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Ritchie Highway A.A. Co Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 15 1969</i>		25B. NAME OF REGISTRAR <i>[REDACTED]</i>		25C. FUNERAL DIRECTOR <i>[REDACTED]</i>		ADDRESS <i>237 Potomac Ave</i>	

BIRTH NO.		69 12381		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 69 12381	
1. NAME OF DECEASED (Type or Print) Charles Schemm				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month Day Year		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1515 Battery Ave.				3. DATE PRONOUNCED DEAD 12 12 69		3:05 p.m.			
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2404				6. SEX male		7. RACE white		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH March 1, 1908				10. AGE (In years last birthday) 61		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Peter J. Schemm Sr.				14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		15. MOTHER'S MAIDEN NAME Mary B. Ward			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No				17. SOCIAL SECURITY NO.		18. INFORMANT Mr. Peter J. Schemm		ADDRESS 3559 4th. St.	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 412.4 Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF: (C)									
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
22A. DATE OF OPERATION				22B. CONDITION FOR WHICH OPERATION WAS PERFORMED				22C. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				ACTUAL SIGNATURE: Werner U. Spitz, M.D.				DATE SIGNED: 12/13/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12 16 69				24C. NAME OF CEMETERY or CREMATORY Cathedral	
24D. LOCATION (City, town, or county) Balto. Md.				24E. DATE REC'D BY HEALTH DEPT. DEC 15 1969				24F. NAME OF REGISTRAR 2365	
24G. FUNERAL DIRECTOR Mc Cully				24H. ADDRESS 130 E. Fort Ave					

ACAPIT BOND

10/10/10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12382</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) Walter E. Raynes</p>		<p>2. DATE AND HOUR OF DEATH Dec. 11, 1969 10:00 A <small>M.</small></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Balto. General Hospital DOA Baltimore, Maryland</p>		<p>4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY 21212</p> <p>C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 5918 Brackenridge Avenue</p>	
<p>5. SEX Male</p>	<p>6. RACE White</p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH March 11, 1917</p>
<p>9. AGE (In years last birthday) 52</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estimator</p>	
<p>11. BIRTHPLACE (State or foreign country) Phila. Pa.</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME Walter George Raynes</p>		<p>14. MOTHER'S MAIDEN NAME Helen Mendenhall</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 204-07-3537</p>	
<p>17. INFORMANT Miriam F. Raynes (Wife)</p>		<p>ADDRESS Same</p>	
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE Ischemic heart disease DUE TO, OR AS A CONSEQUENCE OF: coronary sclerosis</p> <p>(B) coronary sclerosis DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs</p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). old healed pulmonary tuberculosis</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20+ yrs</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 10/3/64 19 to 12/11/69 19 that (I) (we) last saw the deceased alive on 9/18/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>William F. Renner</i></p>		<p>23B. DATE SIGNED 12/12/69</p>	
<p>23C. PHYSICIAN'S NAME (Type) Dr. Wm. F. Renner</p>		<p>23D. ADDRESS 5222 St. Paul Street Balto. 21218</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE Dec. 13/69</p>	
<p>24C. NAME OF CEMETERY or CREMATORY Dulaney Valley Memorial Gardens Cockeysville, Md.</p>		<p>24D. LOCATION (City, town, or county) (State)</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969</p>		<p>25B. NAME OF REGISTRAR Robert E. Faber, M.D.</p>	
<p>25C. FUNERAL DIRECTOR Eugenia M. Seitz</p>		<p>ADDRESS 5209 York Road</p>	
<p>Seitz Funeral Home Balto. Md. 21212</p>		<p>Seitz Funeral Home Balto. Md. 21212</p>	

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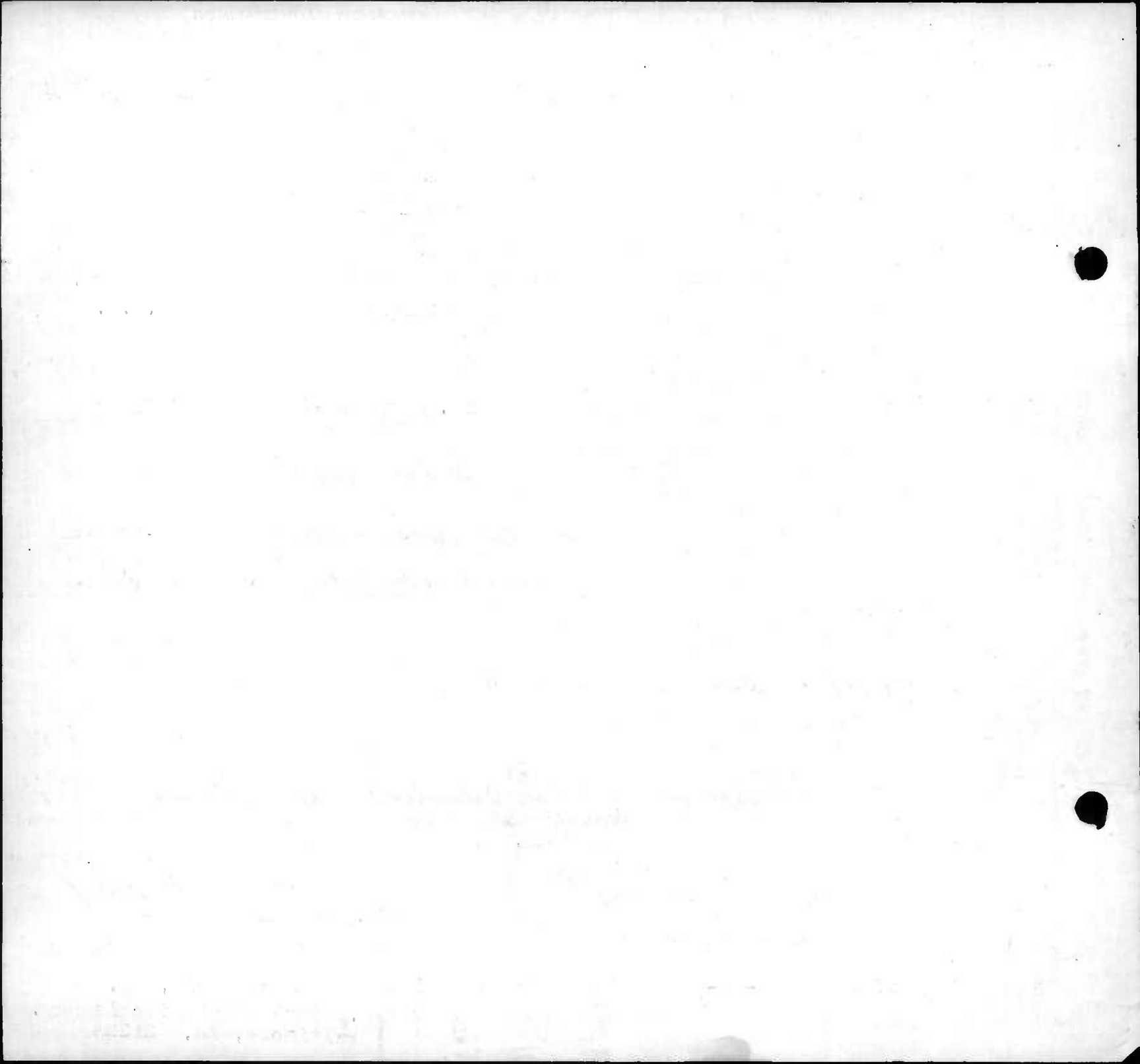
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12383	
D-543		69 12383		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) DONALDSON, James Wesley			
2. DATE AND HOUR OF DEATH 10 December 1969 1240 A M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD The Johns Hopkins Hospital			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY baltimore		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital			
C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 3742 -C McDowell Lane		5. SEX Male 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3/4/60		9. AGE (In years last birthday) 9		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Leroy Donaldson		14. MOTHER'S MAIDEN NAME Mary Blevins	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mary Blevins Slagle	
18. 746.5 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiac arrest (B) Low output cardiac failure DUE TO, OR AS A CONSEQUENCE OF: 12 hrs (C) congenital cardiac defect - corrected 12 hrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/2/9/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Atrio-ventricular canal		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from December 8 - 1969 to December 10 1969 , that (2) (we) last saw the deceased alive on December 10 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul L. Tecklenberg MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-10-69	
23C. PHYSICIAN'S NAME (Type) Paul L. Tecklenberg MD		23D. ADDRESS 601 N. Broadway - Box 161 Baltimore, Md. 21205			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-12-69		24C. NAME OF CEMETERY or CREMATORY Glen Haven Memorial	
24D. LOCATION Glen Burnie, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hgy. Baltimore, Md. 21225	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

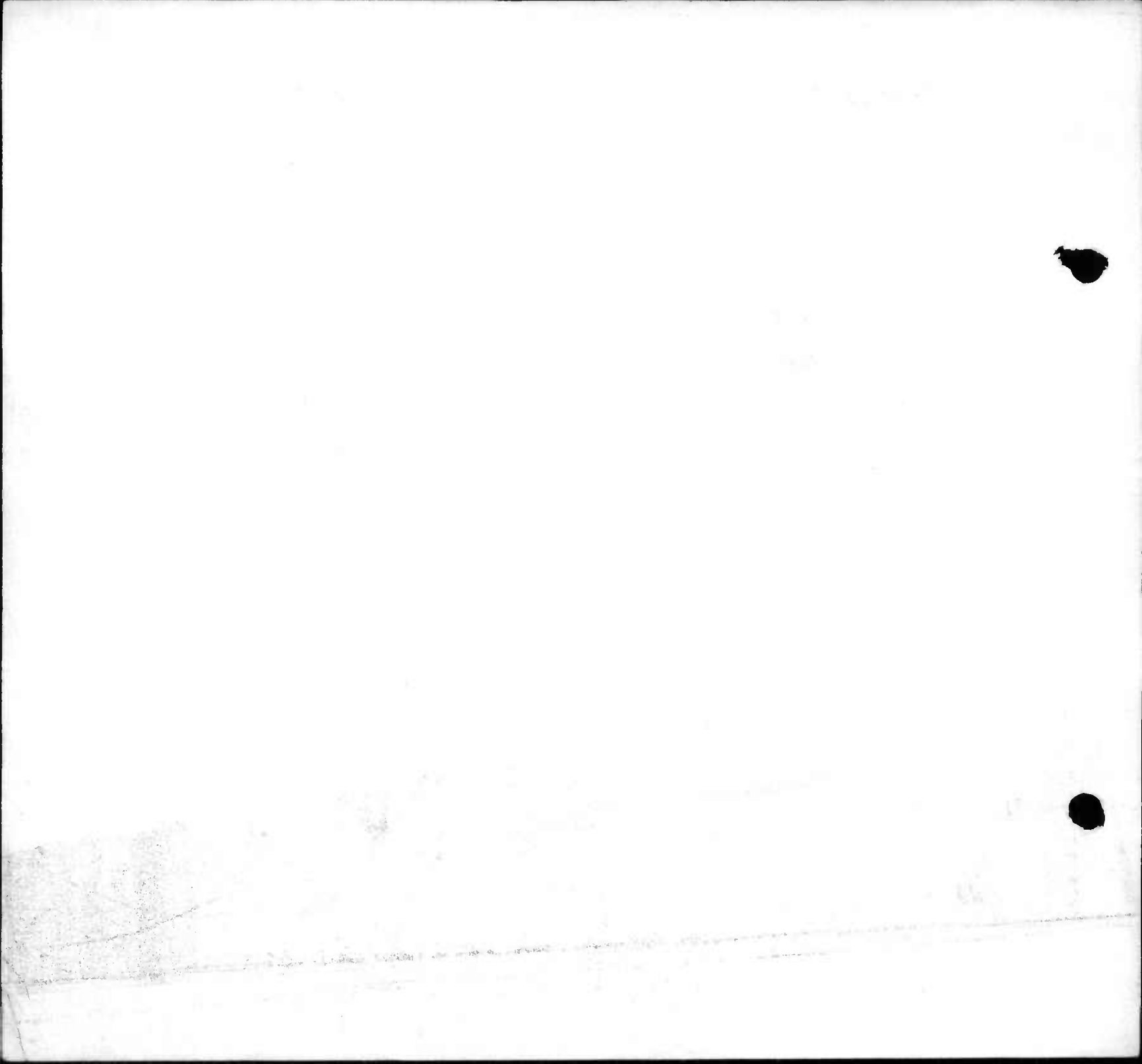
M-420		69 12384		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 69 12384	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) AGNES MELKA MELKA Agnes				2. DATE AND HOUR OF DEATH 12-10-69 4:30AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Harbor View NCC						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY ANNA. C. CITY OR TOWN BALTIMORE MD. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 312 EDISON ST.			
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-8-84		9. AGE (In years last birthday) 85	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10B. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) CZECHOSLOVAKIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VOBALECKY						14. MOTHER'S MAIDEN NAME UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. 219-10-2434		17. INFORMANT MRS. KELLENBENZ			
18. 412-41 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Cerebral and Spinal Arteriosclerosis						CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: Cardiac Failure (C) DUE TO, OR AS A CONSEQUENCE OF: Art. Sci. C-V Dis.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 24 hrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (was hospital) attended the deceased from 8/13/69 to 12/10/69 , that (I) (we) last saw the deceased alive on 12/9/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death.									
23A. SIGNATURE Kenneth Krulovitz						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/10/69	
23C. PHYSICIAN'S NAME (Type) Kenneth Krulovitz MD						23D. ADDRESS 115 W Monument St. Balto. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/13/69		24C. NAME OF CEMETERY or CREMATORY HOLY REDEEMER		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.			
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR George J. Gonce		25C. FUNERAL DIRECTOR GEORGE J. GONCE		ADDRESS 4001 RITCHIE HGY. BALTIMORE, MD. 21225			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-320		69 12385		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12385	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) (BANKS) MARY MAGDALENE BUTTS			
2. DATE AND HOUR OF DEATH 12-12-69 1 5 25 PM							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 38 UNIV. HOSP				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2841			
5. SEX F 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 11-12-92		9. AGE (in years last birthday) 77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) NC, Winston-Salem	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME W.H. BUTTS				14. MOTHER'S MAIDEN NAME Martha Kimble			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Nettie B. Everett	
				ADDRESS 4001 Groveland			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) 410.9+1 25 0.9 Susp Acute Myocardial Infarct				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 10 d			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: 2 Coronary Artery Disease			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CHF, Diabetes Mellitus							
19A. DATE OF OPERATION 12/15/69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Pneumonia Rec.		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/15 19 69 to 12/12 19 69 that (I) (we) lost saw the deceased alive on 12/12 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE B Schlossberg MD				23B. DATE SIGNED 12/17/69			
23C. PHYSICIAN'S NAME (Type) B Schlossberg MD				23D. ADDRESS UNW Hosp			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69		24C. NAME of CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR Mark D. Dyer, F.H.		ADDRESS 1701 Laurens St.	



1

M-415 69 12386

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

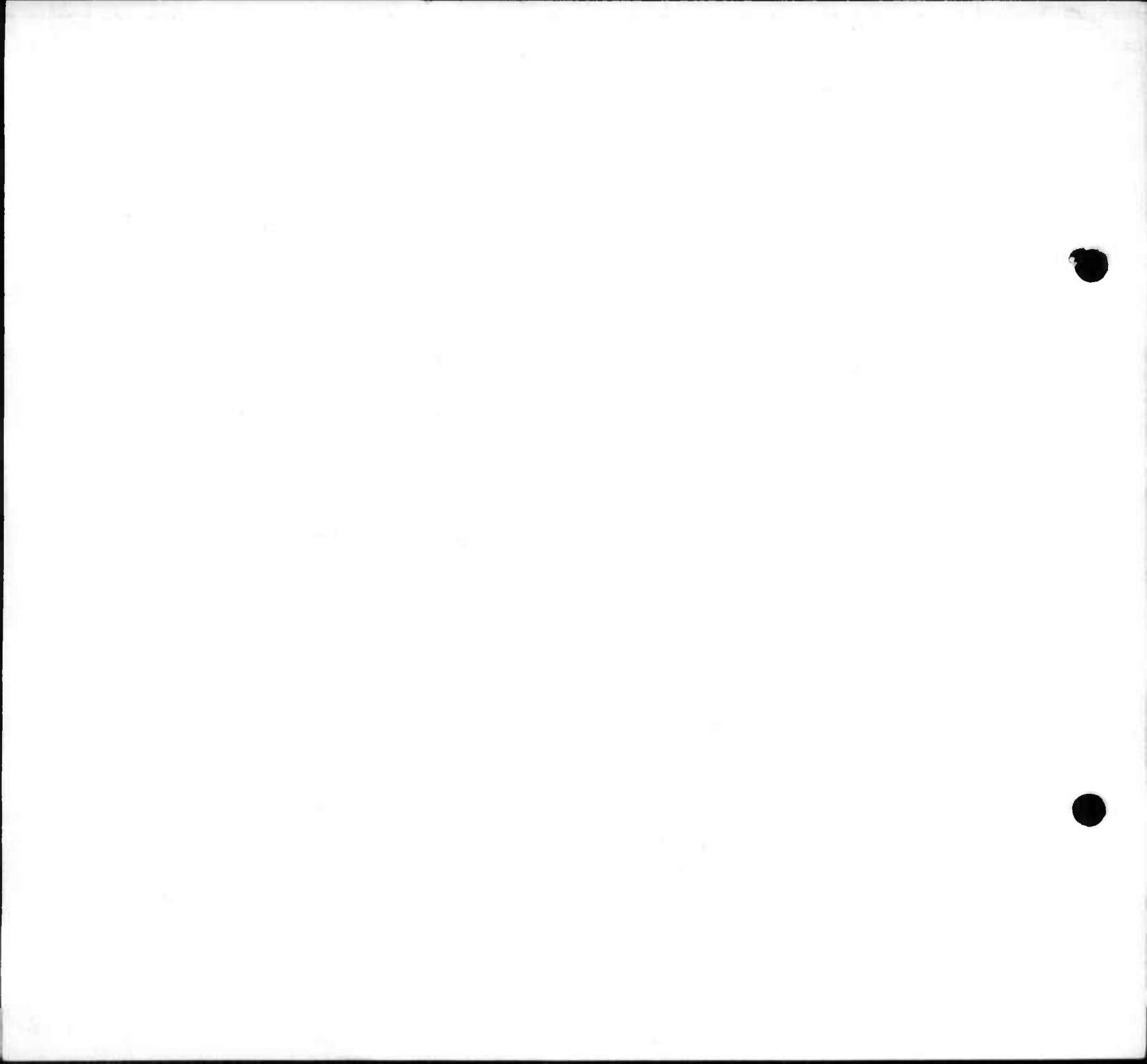
REG. NO. 69 12386

BIRTH NO.		1. NAME OF DECEASED (Type or Print) WILLIE E. MELVIN		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSPITAL		3. DATE PRONOUNCED DEAD Month Day Year Hour December 9, 1969 8:50 P.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 0833	
6. SEX Male	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 9-27-41		10. AGE (In years lost birthday) 28	11. BIRTHPLACE (State or foreign country) Hornett Co., Virginia		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
12. CITIZEN OF U.S.A.		13. FATHER'S NAME Jim Melvin		E. STREET AND NUMBER 2524 E. Hoffman Street	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician		15. MOTHER'S MAIDEN NAME Lucille Elliott		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.	
17. SOCIAL SECURITY NO. 245-62-5293		18. INFORMANT Mrs. Lucille Melvin		ADDRESS 2524 E. Hoffman Street	
19. E965X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wound of Abdomen (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hallway		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 2524 E. Hoffman Street 0833	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-9-69 6:58 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Gunshot wound of abdomen	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Ronald N. Kornblum M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/10/69					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-69		24C. NAME of CEMETERY or CREMATORY Mt. Calvary Cemetery	
24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			
25B. NAME OF REGISTRAR 969000		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT F.H. 1701 Laurens Street			

ACADEMIC RECORD

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
C-200		69 12387		69 12387	
1. NAME OF DECEASED (Type or Print) PERRY CHASE			2. DATE AND HOUR OF DEATH 12/13/69 10:30 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIVERSITY HOSPITAL			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY 2002		
5. SEX M 6. RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 6/30/29 9. AGE (In years last birthday) 40 If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION			11. BIRTHPLACE (State or foreign country) MD. Balto.		
10B. KIND OF BUSINESS OR INDUSTRY —			12. CITIZEN OF WHAT COUNTRY? USA.		
13. FATHER'S NAME WILLIAM CHASE			14. MOTHER'S MAIDEN NAME DORAPHINE RAIKES		
15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. CHASTINE HOSPITAL CHART.		
18. 400.31 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 YEAR		
(A) IMMEDIATE CAUSE CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF:					
(B) MINOR HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF:					
(C) MALIGNANT HYPERTENSION					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0 None		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) —	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) —		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? —	
22. I certify that (I) (this hospital) attended the deceased from 11/23 1969 to 12/13 1969 that (I) (we) last saw the deceased alive on 12/13 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Paul F. Dyett M.D. DEGREE			23B. DATE SIGNED 12/13/69		23C. PHYSICIAN'S NAME (Type) Paul F. Dyett
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 12/18/69		24C. NAME of CEMETERY or CREMATORY Will. Amburg Meth. Ch. Cem.
24D. LOCATION (City, town, or county) Easton			24E. LOCATION (City, town, or county) Maryland		
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			25B. NAME OF REGISTRAR Robert E. Taylor		
25C. FUNERAL DIRECTOR Robert E. Taylor			25D. ADDRESS 1701 Laurens St		



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12388	
BIRTH NO. D-620 69 12388 69-05794			
1. NAME OF DECEASED (Type or Print) COREY J. DORSEY		2. DATE AND HOUR OF DEATH DEC. 14, 1969 11:00 AM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNIV. OF MARYLAND HOSPITAL 22 S. GREENE ST.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN BALTO. 21230 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1321 BAYARD ST	
5. SEX M	6. RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-29-69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 8
11. BIRTHPLACE (State or foreign country) BALTO. MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN DORSEY		14. MOTHER'S MAIDEN NAME SHEILA THOMAS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. -0-	17. INFORMANT Miss Sheila Thomas
		ADDRESS 1321 Bayard St	
18. 03891 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
(A) IMMEDIATE CAUSE RESPIRATORY ARREST DUE TO, OR AS A CONSEQUENCE OF: (B) PNEUMONIA & PLEURAL EFFUSION DUE TO, OR AS A CONSEQUENCE OF: (C) BACT. SEPSIS.			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hrs. 48 hrs.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from DEC. 12, 1969 to DEC. 14, 1969 that (I) (we) last saw the deceased alive on DEC. 14, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Stanley Brull M.D.		23B. DATE SIGNED Dec. 14, 1969	
23C. PHYSICIAN'S NAME (Type) STANLEY BRULL M.D.		23D. ADDRESS 22 S. GREENE ST. BALTO. MD 21201	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 12/17/69	24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
		25C. FUNERAL DIRECTOR Horton & Dyett F.H.	
		ADDRESS 1701 Laurens St.	



69 12389

CERTIFICATE OF DEATH

REG. NO.

69 12389

RICHARD H. YOUNG

2. DATE AND HOUR OF DEATH

12-10-69

11.2 5 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

33 THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

MARYLAND

BALTIMORE CITY 2552

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2840 POTTEE STREET

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

5-22-13

9. AGE (in years
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.

Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Long Shoreman

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Goochland, Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Young

14. MOTHER'S MAIDEN NAME

Francis Simms

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Louis A. Young 2840 Potee Street

18. 038,91

CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

RENAL FAILURE

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from September 10 19 69 to December 10 19 69
that (I) (we) last saw the deceased alive on December 10 19 69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Richard Bensinger MD

DEGREE

Attending ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/10/69

23C. PHYSICIAN'S
NAME (Type)

Richard Bensinger MD

DEGREE

23D. ADDRESS

JOHNS HOPKINS HOSPITAL

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-15-69

24C. NAME OF CEMETERY or CREMATORY

Arbutus Memorial Park

24D. LOCATION

(City, town, or county)

Baltimore,

Maryland

25A. DATE REC'D BY HEALTH DEPT.

DEC 15 1969

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

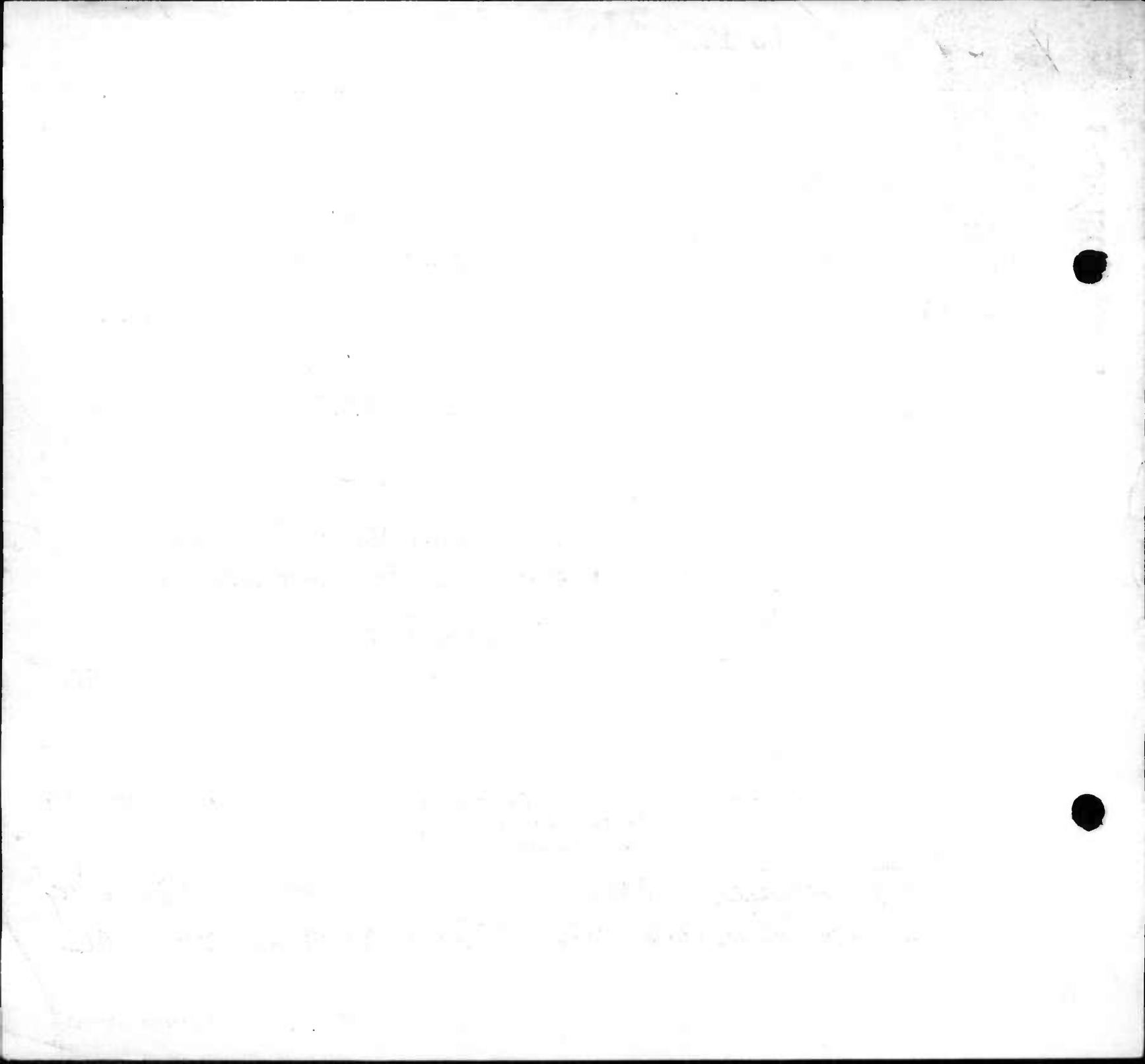
MORTON & DYETT

ADDRESS

F.H. 1701 Laurens Street

FUNERAL DIRECTOR: IMPORTANT

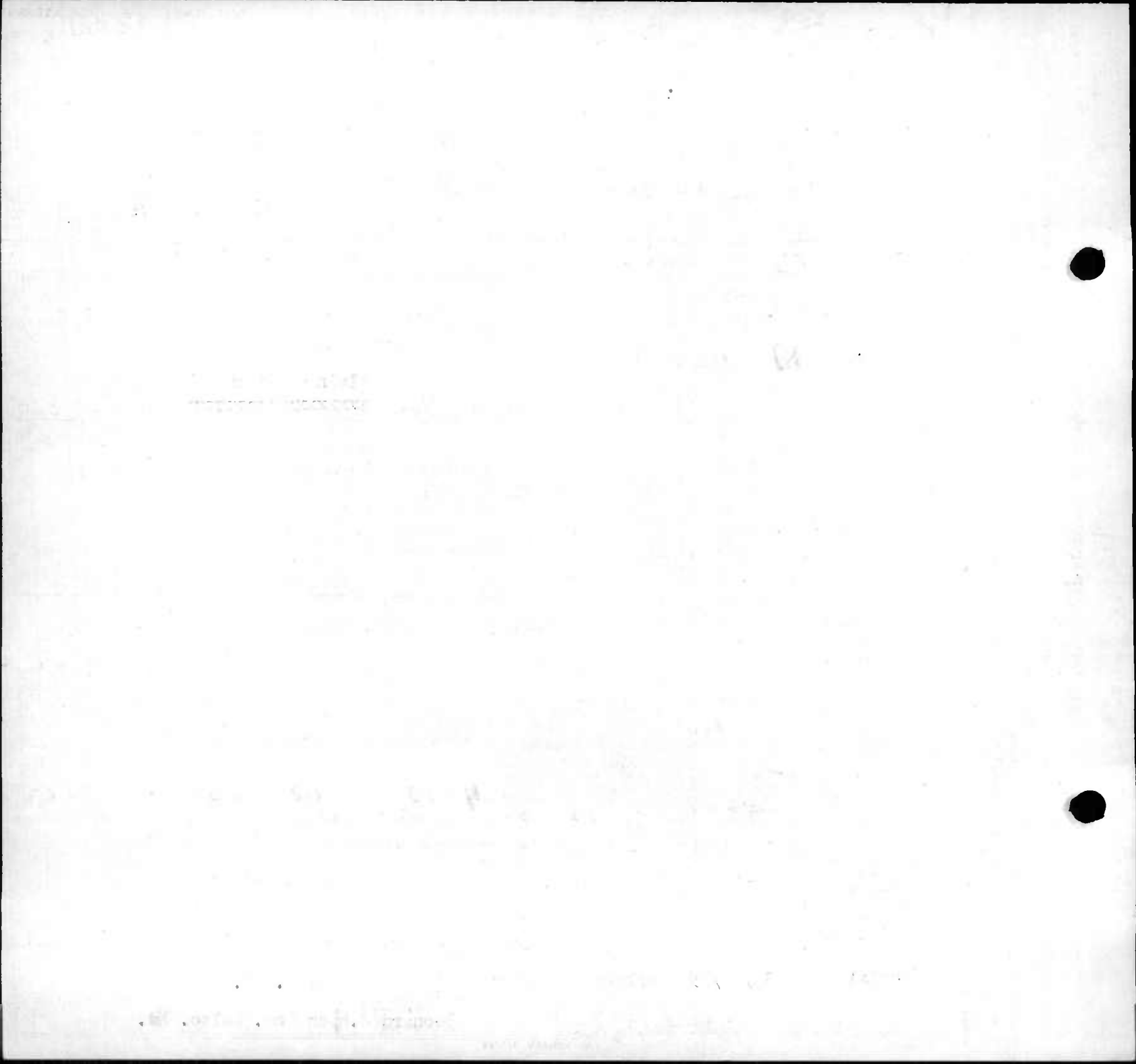
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital or the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Dec. was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance or deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12390	
W-255 69 12390		CERTIFICATE OF DEATH			
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Lillian L. Nickman		2. DATE AND HOUR OF DEATH Dec. 13, 1969 1205 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balt.		C. CITY OR TOWN Baltin. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION Montello State Hosp.		E. STREET AND NUMBER 6405 Hill Top Ave. 21205			
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-25-88	9. AGE (In years lost birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hs wife.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Hamilton		14. MOTHER'S MAIDEN NAME Diola Edwards		12. CITIZEN OF WHAT COUNTRY? USIT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-14-1695A		17. INFORMANT Melvin Wickman ADDRESS 6405 Hill Top Bulf.	
18. 486X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Bilat. Pneumonia (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). D. S. S. Anteroscientific Vase. Dis.		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4-22-1966 to 12-13-1969 , that (I) (we) last saw the deceased alive on 12-13-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George F. Ritchie M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-13	
23C. PHYSICIAN'S NAME (Type) George F. Ritchie M.D.		23D. ADDRESS Montebello State Hosp.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12/16/69	24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR Leonard J. Nick Inc. Balto. Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

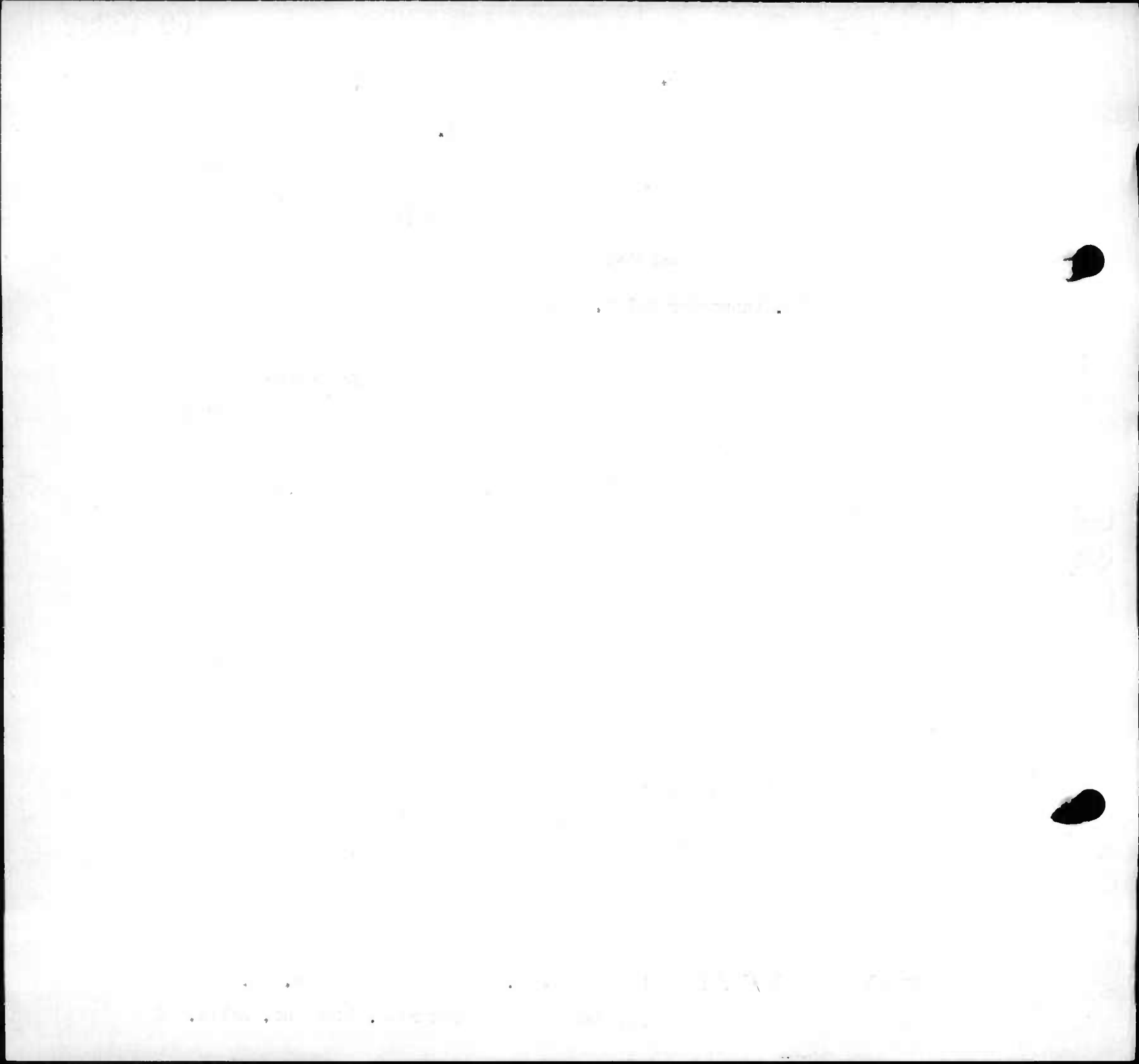
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12391	
P-250 69 12391				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) PICCIONE, CARMELO		2. DATE AND HOUR OF DEATH 12/13/69 10:30 p M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Union Memorial Hospital 44		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore City C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 6310 Harford Rd (21214)			
5. SEX Male	6. RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 2/26/1883		9. AGE (In years, Months, Days) 86
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Public Works		10B. KIND OF BUSINESS OR INDUSTRY Balto. City		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Biagio Piccione		14. MOTHER'S MAIDEN NAME Pauline	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-54-2915		17. INFORMANT ADDRESS Marguerita Piccione same	
18. 250.1 I CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Pneumonia Diabetes & ASCVD CVA Weeks 10 yrs + 1 year	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) -		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) -		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) -	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) THIS HOSPITAL		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? -	
22. I certify that the hospital attended the deceased from 12/10 19 69 to 12/13 19 69 , that (we) last saw the deceased alive on 12/13 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death.					
23A. SIGNATURE J.H. Mulholland				23B. DATE SIGNED 12/13/69	
23C. PHYSICIAN'S NAME (Type) J.H. MULHOLLAND M.D.				23D. ADDRESS THE UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/17/69		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			
25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Buck Inc. Balto. Md.			

1997-1998

FUNERAL DIRECTOR: IMPORTANT

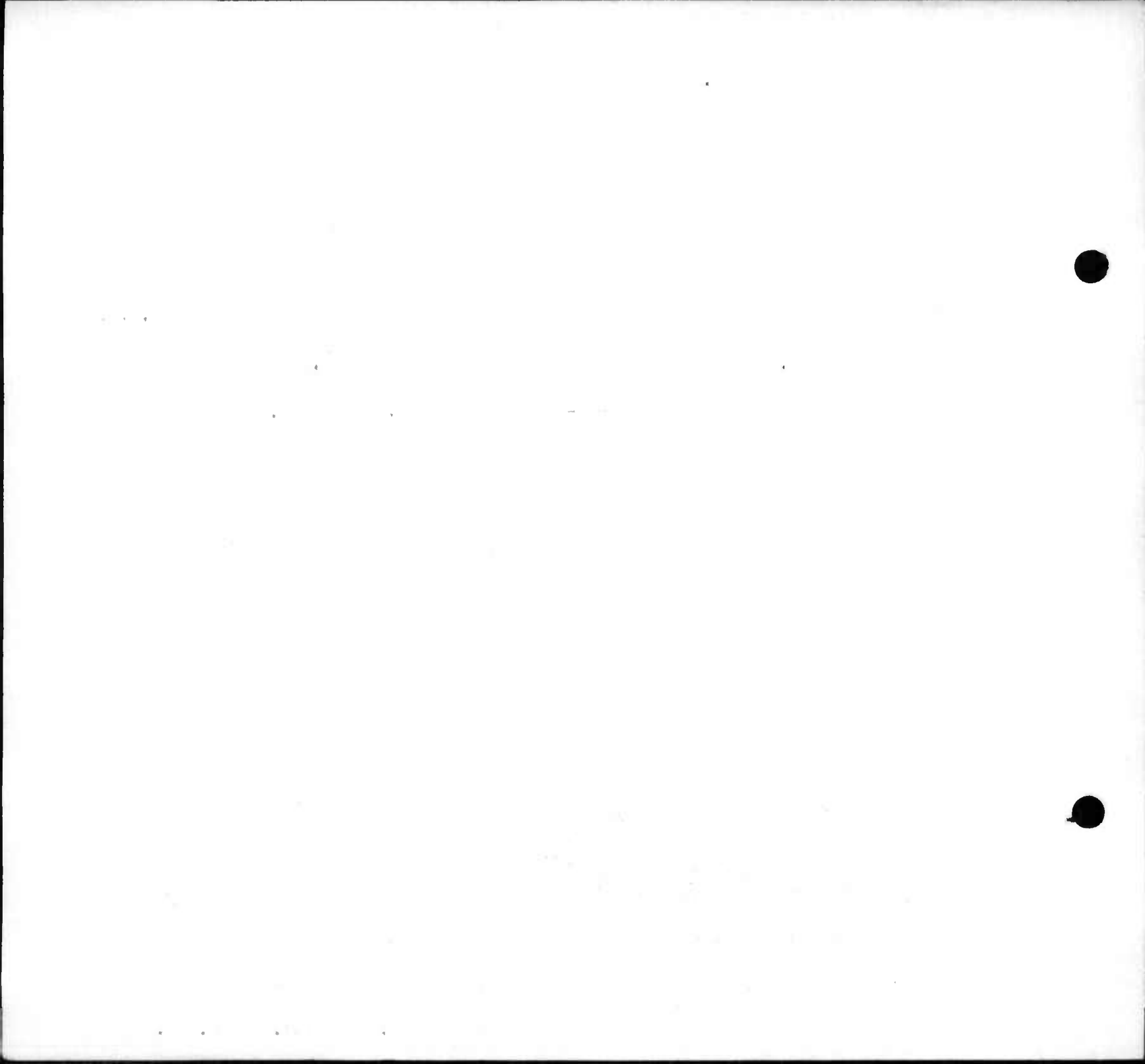
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-362		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12392	
BIRTH NO. 69 12392		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) FRANKLIN L. PATTERSON		2. DATE AND HOUR OF DEATH 4/13/69 4:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2702		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GEN. HOSP.		D. STREET ADDRESS (If rural, give location) 3102 Montebello TERR.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 8/29/05	9. AGE (In years last birthday) 64	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Bld. Inspector Balto. City		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank Patterson		14. MOTHER'S MAIDEN NAME Idea Frank	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 214-18-2291		17. INFORMANT Wife Louise Patterson ADDRESS admission sheet same	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial INFARCTION vs. Acute Embol		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO		(B) DUE TO	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/11 19 69 to 12/13 19 69 , that (I) (we) last saw the deceased alive on 12/13 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Enrique A.		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/13/69	
23C. PHYSICIAN'S NAME (Type) ENRIQUE A.		23D. ADDRESS M. G. H.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/69		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Leonard J. Rack Inc. Balto. Md	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

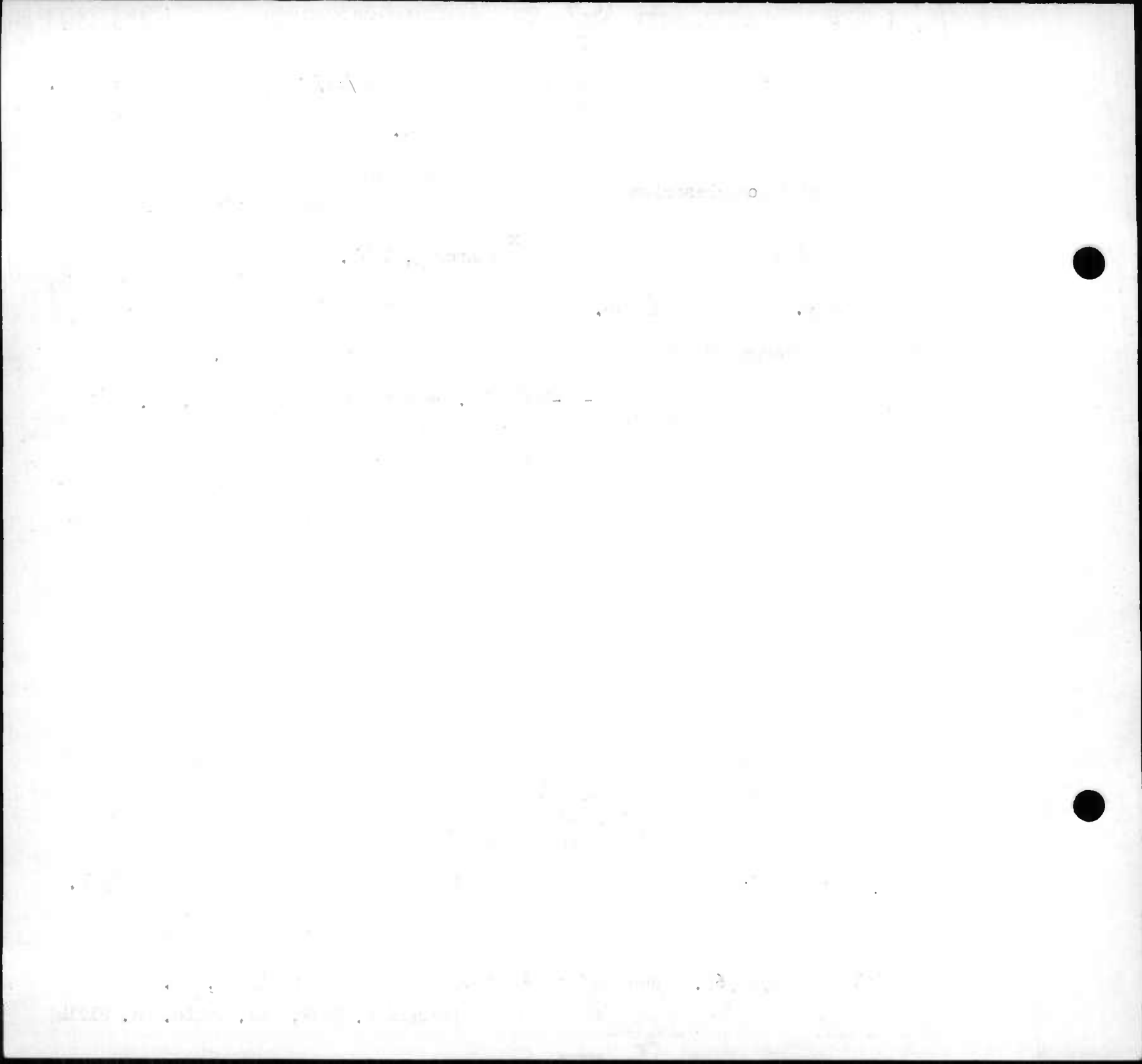
BALTIMORE CITY HEALTH DEPARTMENT				X REG. NO. 69 12393	
69 12393 CERTIFICATE OF DEATH					
BIRTH NO. <u>M-460</u>					
1. NAME OF DECEASED (Type or Print) <u>ALICE E. MILLER</u>		2. DATE AND HOUR OF DEATH <u>12-12-69 10¹⁸ A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>37 MERCY HOSP.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>BALTIMORE</u> B. COUNTY <u>M.D.</u> C. CITY OR TOWN <u>5300</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>208 LYNDALE AVE. #36.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-30</u>	9. AGE (In years last birthday) <u>38</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>MELVIN A. JACKSON</u>		14. MOTHER'S MAIDEN NAME <u>DOLORES M. KUHN</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-28-9068</u>		17. INFORMANT <u>William E. Miller Jr. same</u>	
18. <u>174 X I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE Cerebral edema DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) Cerebral metastatic Ca DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) Carcinoma of breast w/o</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>12-7-69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-7-69</u> 19 <u>69</u> to <u>12/12/69</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/12/69</u> 19 <u>69</u> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>MANUELA RIBEIRO, M.D.</u>		23B. DATE SIGNED <u>12/12/69</u>		23C. PHYSICIAN'S NAME (Type) <u>MANUELA RIBEIRO, M.D.</u>	
23D. ADDRESS <u>MERCY Hospital</u>		23E. FUNERAL DIRECTOR, ADDRESS <u>Leonard J. Ruck Inc. Balto. Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/16/69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>GARDENS of FAITH Cem.</u>	
24D. LOCATION <u>BALTO. MD.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>DEC 15 1969</u>			
24F. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		24G. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

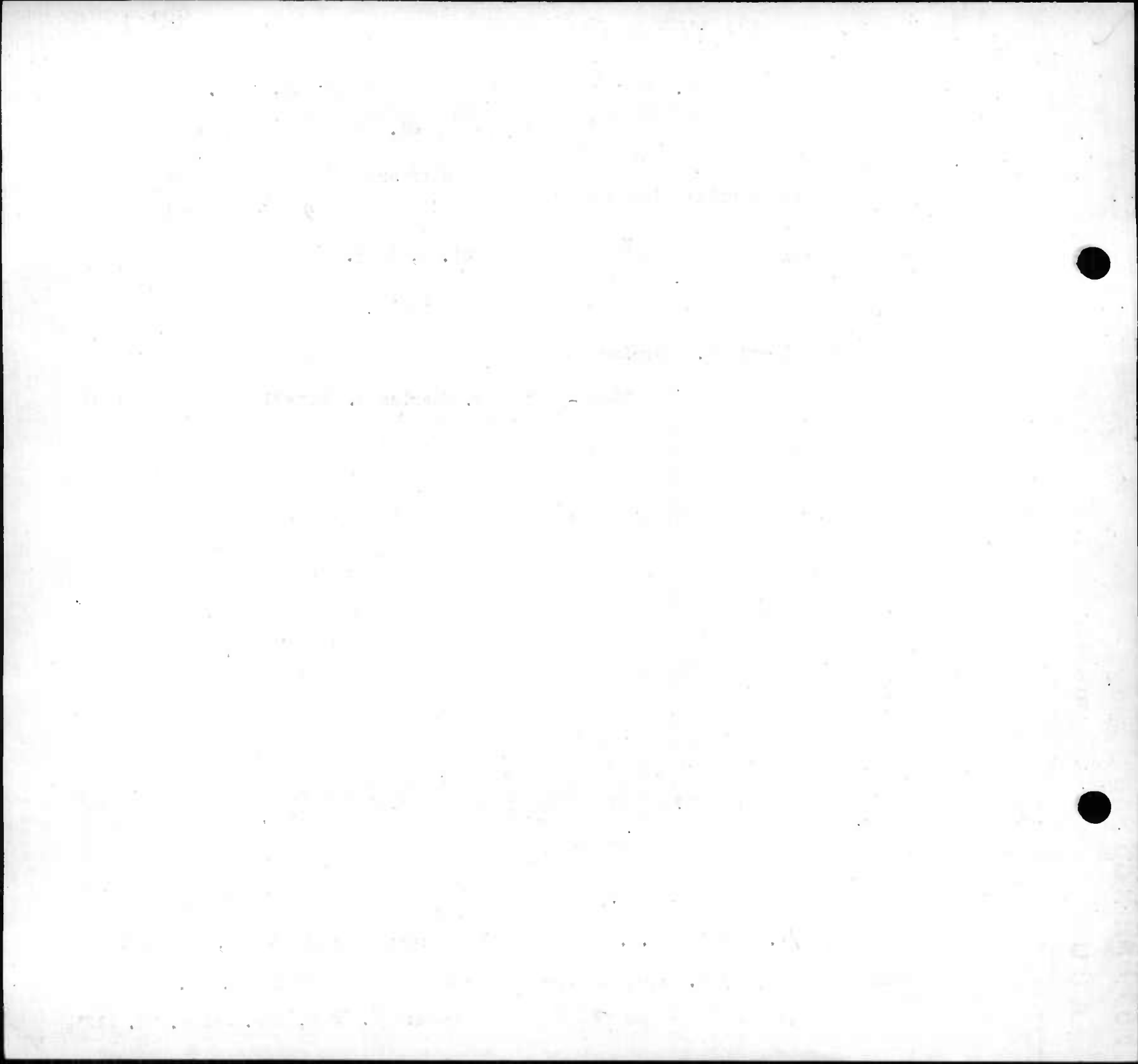
P-413 69 12394		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12394	
BIRTH NO.		CERTIFICATE OF DEATH		1	
1. NAME OF DECEASED (Type or Print) Elizabeth Jane Philpot		2. DATE AND HOUR OF DEATH 12/12/69 12:40 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 90 Gould Convalesarium		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Md. B. COUNTY 2702		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female 6. RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1, 1887. 9. AGE (In years last birthday) 82		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Secty.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Philpot	
14. MOTHER'S MAIDEN NAME Sarah E. Catrup		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 442-01-1668	
17. INFORMANT Mr. Malcolm Philpot, Phoenix, Md.		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Arteriosclerotic C. & dis (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from June 10 1964 to Dec 12 1969 , that (I) (we) lost saw the deceased alive on Dec 1 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE George Sawyer M.D.		23B. DATE SIGNED 12/12/69.		23C. PHYSICIAN'S NAME (Type) GEORGE SAWYER, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/15/69.		24C. NAME OF CEMETERY or CREMATORY Mount Olivet Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		24E. FUNERAL DIRECTOR Leonard J. Guck, Inc. Balto. Md. 21214		24F. ADDRESS	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR Robert E. Taber, Md.		25C. FUNERAL DIRECTOR Leonard J. Guck, Inc. Balto. Md. 21214	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12395	
C-654 69 12395				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		DORIS H. CORNELL		December 13, 1969. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 Union Memorial Hospital			A. STATE Md.		B. COUNTY
C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 3932 Ednor Road					
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 1, 1923.	9. AGE (In years last birthday) 46
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Albert W. Harding		14. MOTHER'S MAIDEN NAME Augusta Zorbach		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-18-9414		17. INFORMANT Mr. Charles S. Cornell	
				ADDRESS (Same)	
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary Thrombosis (B) Hypertensive Cardiovascular Disease (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/21 1958 to Dec 13 1969, that (I) (we) last saw the deceased alive on 11/13 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE L.B. Stevens				23B. DATE SIGNED 12/15/69	
23C. PHYSICIAN'S NAME (Type) L/B. Stevens M.D.				23D. ADDRESS 3400 Erdman Ave Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/17/69		24C. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery	
				24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969		25B. NAME OF REGISTRAR John E. Sals, M.D.		25C. FUNERAL DIRECTOR Leonard J. Buck, Inc. Balto. Md. 21214	



BIRTH NO.		1. NAME OF DECEASED (Type or Print) M. Lillian Kammer		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 5104 Ardmore Way		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 13 69 3:30 p. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2741	
6. SEX female	7. RACE white	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Jan. 6, 1888.		10. AGE (In years last birthday) 81	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Mary Hild	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Harold Buchman, 1501 Tower Bldg. 21202	
19. 41241		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtento, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) NO	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23.					
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/14/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/69.		24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. DEC 15 1969			
25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR ADDRESS Leonard J. Ruck, Inc. Balto. Md. 21214			

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250		69 12397		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X REG. NO. 69 12397	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES E JACKSON				2. DATE AND HOUR OF DEATH 12-13-69 1:50 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bohdon Hill Nursing Home						A. STATE MARYLAND		B. COUNTY BALTO. CO.	
						C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
						E. STREET AND NUMBER 29 HILLSIDE AVE, COCKEYSVILLE 21030			
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-10-17		9. AGE (In years lost birthday) 52		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roller operator				10B. KIND OF BUSINESS OR INDUSTRY contractor		11. BIRTHPLACE (State or foreign country) md.		12. CITIZEN OF WHAT COUNTRY? U. S. A	
13. FATHER'S NAME Lawrence Jackson						14. MOTHER'S MAIDEN NAME Rose May Young			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 212-14-3528		17. INFORMANT Bohdon Hill Nursing Home		ADDRESS 1400 JOHN ST.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) Ca. lung. left generalized retention						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH rather			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 12/13		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12/12 19 69 to 12/13 19 69 . that (I) (we) last saw the deceased alive on 12/13 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Al Markey						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/16/69	
23C. PHYSICIAN'S NAME (Type) ALLAN H. MACHT M.D.						23D. ADDRESS 2 E Real St Balt Md 21202			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 12/17/69		24C. NAME OF CEMETERY or CREMATORY Basil Methodist		24D. LOCATION (City, town, or county) (State) Cockeysville, Balto. Co. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. FUNERAL DIRECTOR Wm. J. Chatman, Jr.		ADDRESS 1701 M.P. Culler			

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69 12398

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12398

BIRTH NO.

1. NAME OF DECEASED (Type or Print) John L. Knickman SR.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Dec 24, 1969	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 44 Union Memorial Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 14 69 3:06 a.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1307	
9. DATE OF BIRTH Dec. 21. 1893		10. AGE (In years last birthday) 73	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME ?		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes. 1st W.W.	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS John L. Knickman. 840 W. 36th St.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, public bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE OF EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/14/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 18, 1969	
24C. NAME OF CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Balto.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Paul E. Cheney Jr.	
25C. FUNERAL DIRECTOR Paul E. Cheney Jr.		ADDRESS 3615 Chestnut Ave.	

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12399	
K-500 69 12399				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		KAIN, MARY C		12-10-69 11:20 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
90 KEY CIRCLE Hospice 1214 Eutaw Pl. Balto. Md. 21217			MARYLAND 1338		
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			Balto. YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
8. DATE OF BIRTH 2-4-07 9. AGE (In years last birthday) 62			E. STREET AND NUMBER 3702 CLIPPER ROAD		
			1214 Eutaw Pl.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		-		Balto. County	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Stanslaw, Blake		Annie, Brady		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
-		217-50-668		MARY L PAYNE 3711 CLIPPER RD.	
18. 41241 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Circulatory failure 10 days		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) ACBD - CUA 5 yrs		
			(C)		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10-10-69 to 12-10-69, that (I) (we) last saw the deceased alive on 12-9-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Richard R. Rigler				12-10-69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
RICHARD R. RIGLER				1214 Eutaw place	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		12-13-69		NEW CATHEDRAL	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 16 1969		John E. Taylor, Md.		3615 Chestnut Ave.	

1947-1948

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1949-1950

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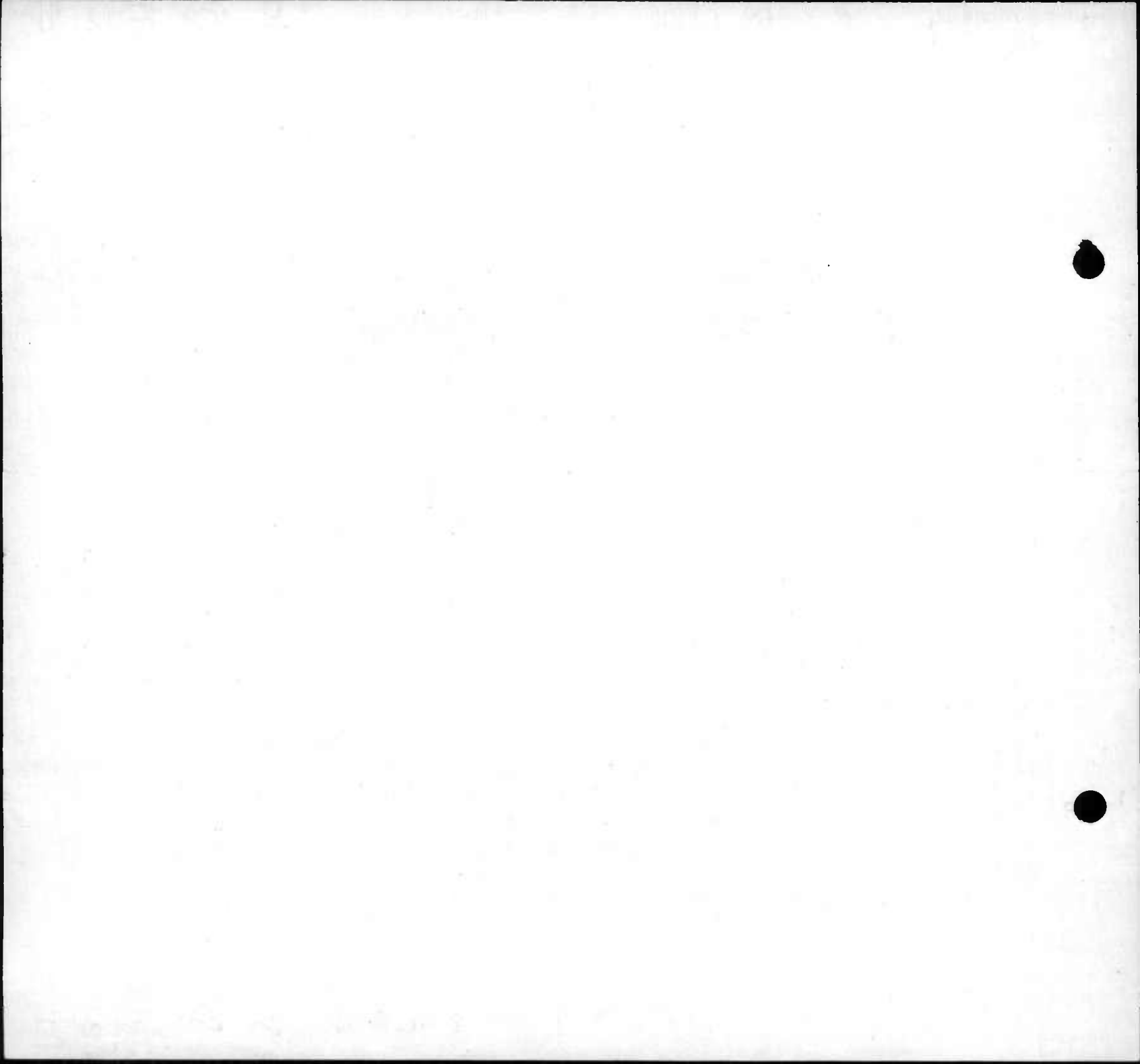
1966-1967

1967-1968

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

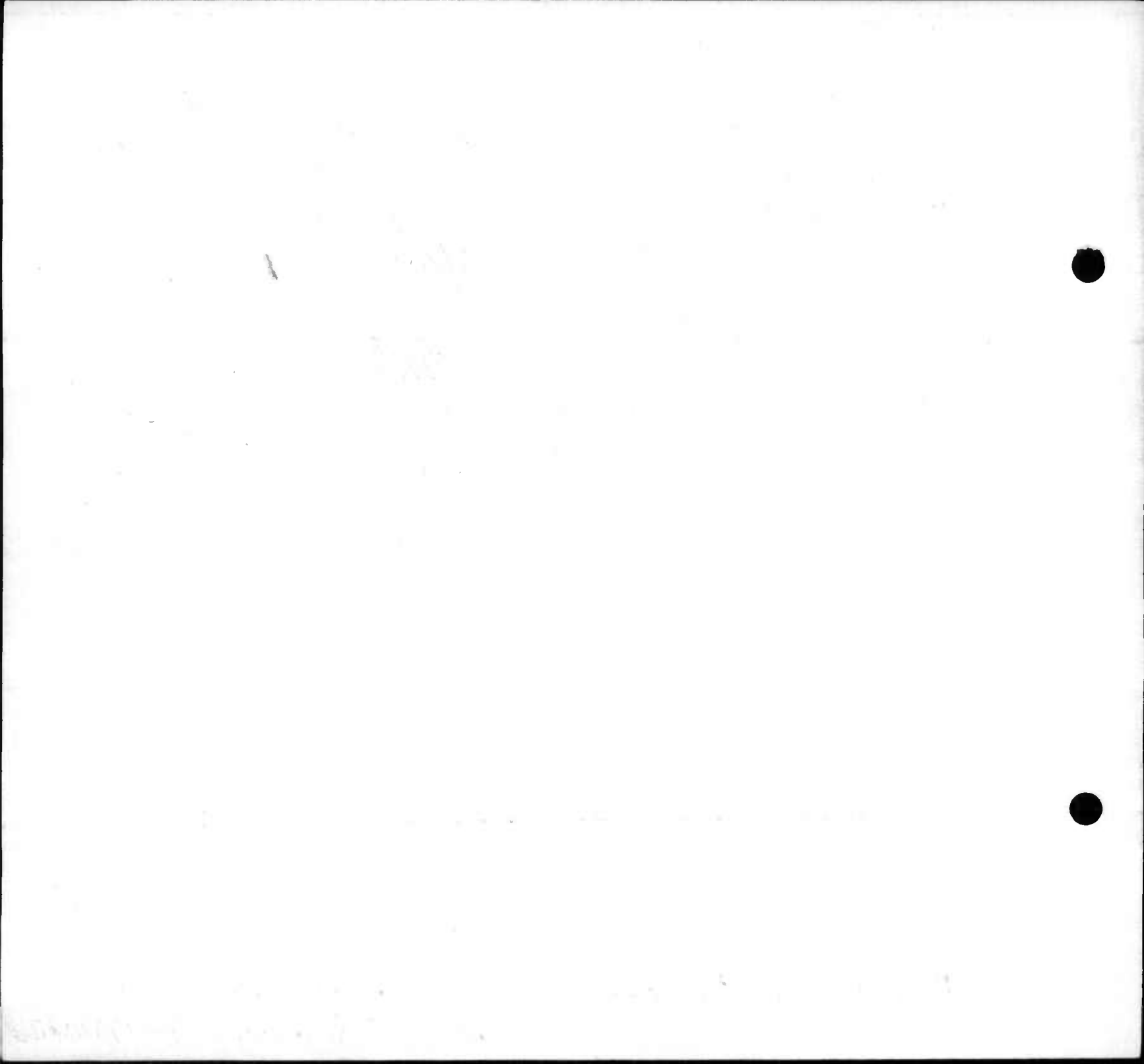
S-460 69 12400		BALTIMORE CITY HEALTH DEPARTMENT		69 12400	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Capitola Edra Scheller		Dec 12 1969 12:20 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 00		A. STATE Md		B. COUNTY 21234	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2337 Eastern Ave		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 2337 Eastern Ave.			
5. SEX F	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7 1919	9. AGE (In years lost birthday) 50 yrs	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife - SEWING MACHINE OPERATOR		10B. KIND OF BUSINESS OR INDUSTRY SHIRT FACTORY		11. BIRTHPLACE (State or foreign country) Mondamin Iowa	
13. FATHER'S NAME Edward Routier		14. MOTHER'S MAIDEN NAME Rena Adams		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 166-18-2309		17. INFORMANT Aih L. Scheller	
				ADDRESS 2337 Eastern Ave	
18. 203 XI		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Severe Arteriosclerosis			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) Multiple Myeloma			
		(C) _____			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 9-8-69 to 12-12-69, that (I) (we) last saw the deceased alive on 12-12-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theodore T. Ryzniak				23B. DATE SIGNED 12-12-69	
23C. PHYSICIAN'S NAME (Type) THEODORE T. RYZNIAK				23D. ADDRESS 429 S. Charles St	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-16-69		24C. NAME OF CEMETERY OR CREMATORY NORTHWOOD CEM.	
				24D. LOCATION (City, town, or county) (State) LEHIGH, CO. Penn	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR J. J. Fialkowski		25C. FUNERAL DIRECTOR 2007 EASTERN AVE. BALTO. MD. 21231	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		69 12401		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 12401	
BIRTH NO.											
1. NAME OF DECEASED (Type or Print) <u>James R. Brown</u>						2. DATE AND HOUR OF DEATH <u>10²⁵ 12/13/69</u> <u>A</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, or institution residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION <u>38 Univ. Md. Balt. Md.</u>						A. STATE <u>MD.</u>					
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)						B. COUNTY <u>Dorchester</u>					
						C. CITY OR TOWN <u>HURLOCK</u>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
						E. STREET AND NUMBER <u>21643</u>					
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/10/08</u>		9. AGE (in years last birthday) <u>63</u>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane operator</u>						10B. KIND OF BUSINESS OR INDUSTRY <u>CONSTRUCTION</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JAMES H. BROWN</u>						14. MOTHER'S MAIDEN NAME <u>BERNICE SOWERS</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>218-05-3526</u>		17. INFORMANT <u>WIFE</u>		ADDRESS <u>Same</u>	
18. <u>410.91</u> CAUSE OF DEATH											
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHF</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction</u>			<u>15 min</u>		
						(C) <u>TACHY ARRHYTHMIA</u>					
II											
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION <u>12/12/69</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/12</u> 19 <u>69</u> to <u>12/13</u> 19 <u>69</u> that (I) (we) last saw the deceased alive on <u>12/12</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>Howard Wallach, MD</u>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>12/13/69</u>		
23C. PHYSICIAN'S NAME (Type) <u>HOWARD WALLACH, MD</u>						23D. ADDRESS <u>UNIV MD.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>				24B. DATE <u>12/16/1969</u>		24C. NAME OF CEMETERY OR CREMATORY <u>FIREMEN'S</u>				24D. LOCATION (City, town, or county) (State) <u>SHARPTOWN, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 16 1969</u>				25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>				25C. FUNERAL DIRECTOR <u>NEW NAM FUNERAL HOME, SHARPTOWN, MD.</u>			



M-460

69 12402

BALTIMORE CITY HEALTH DEPARTMENT

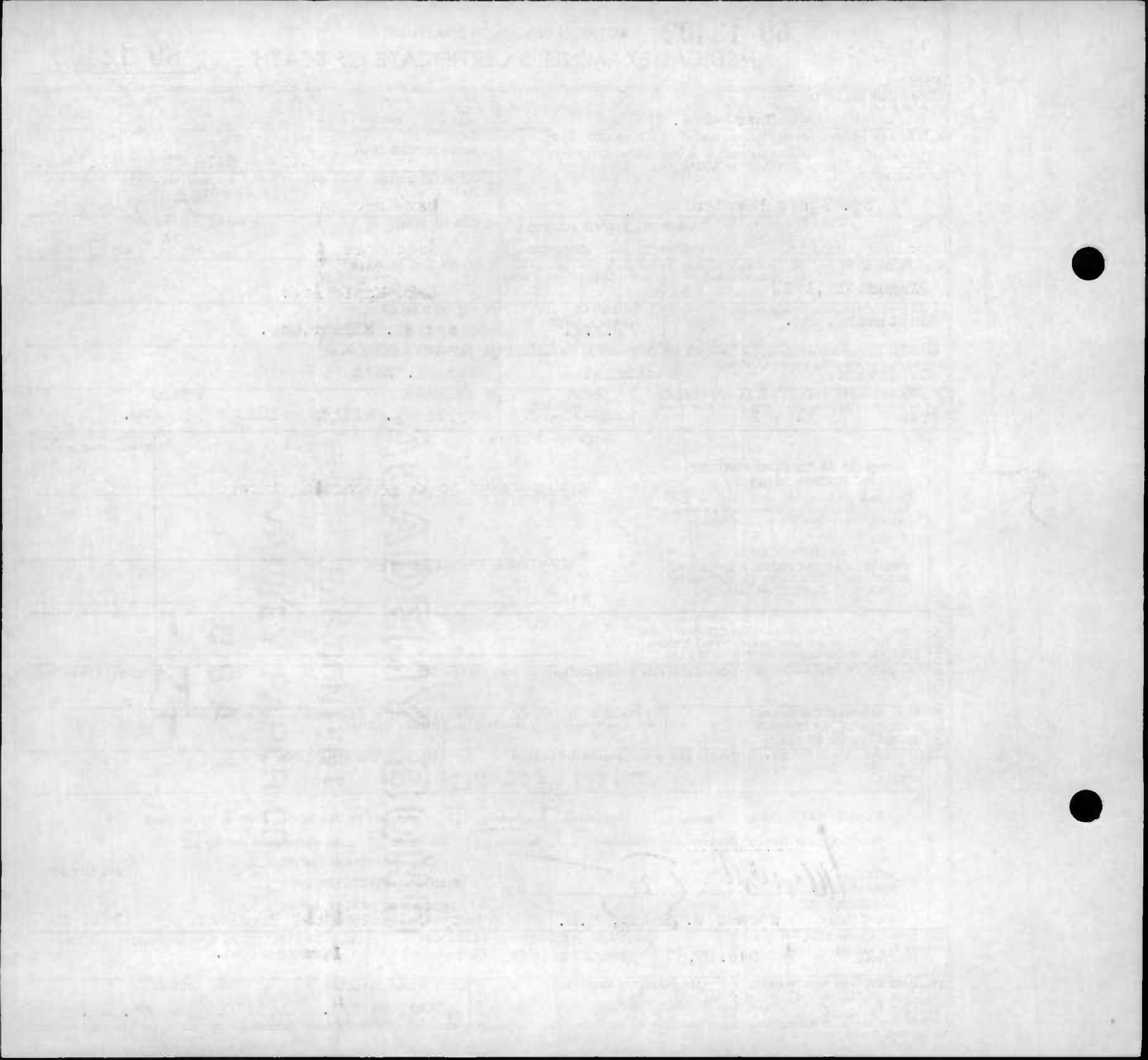
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12402

BIRTH NO.

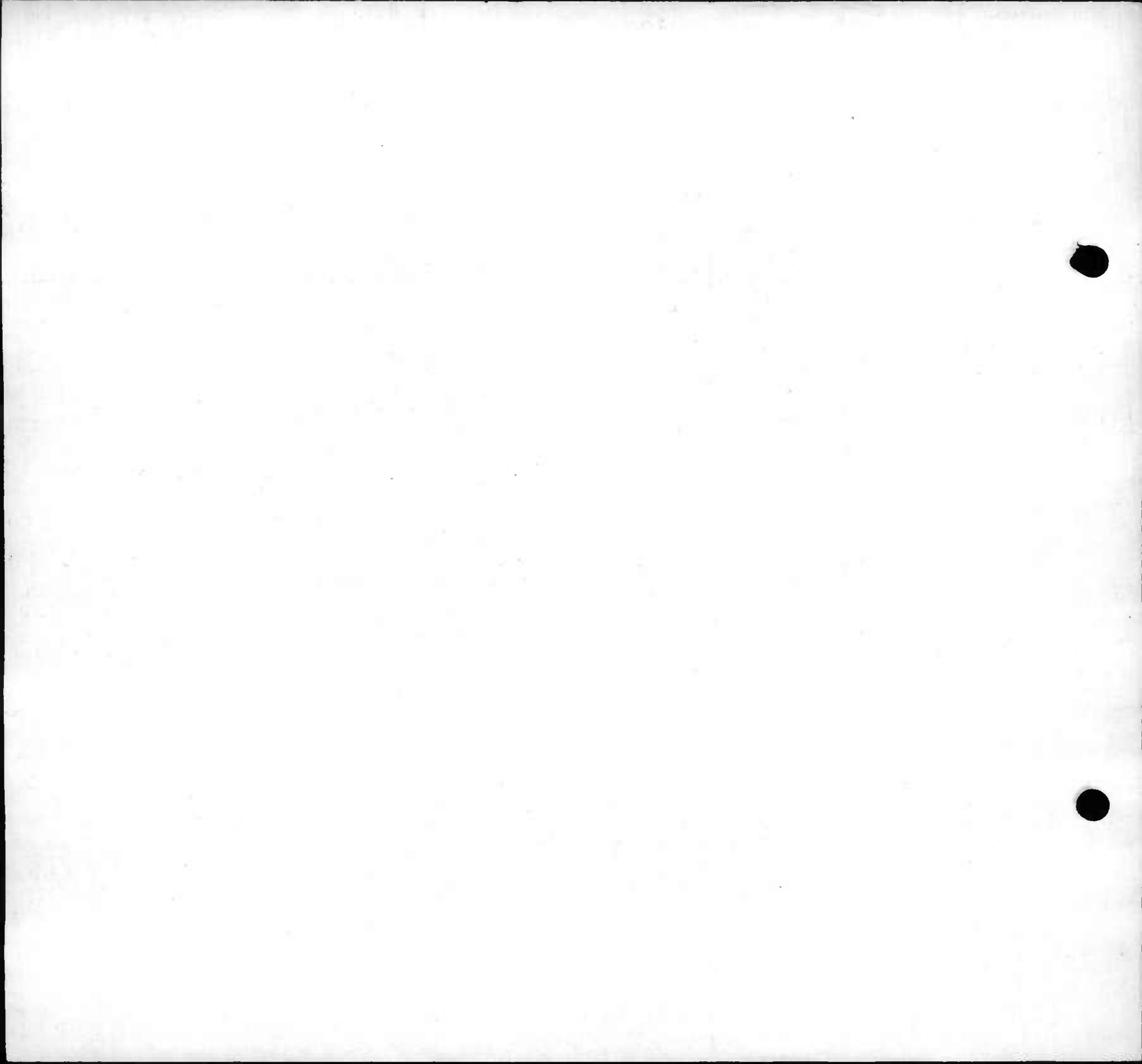
1. NAME OF DECEASED (Type or Print) Charles S. Miller		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 40 St. Agnes Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 12 69 2:10 p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
9. DATE OF BIRTH August 18, 1921		10. AGE (In years last birthday) 48	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George S. Miller, Sr.		14. STREET AND NUMBER 1320 Maple Ave.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		14B. KIND OF BUSINESS OR INDUSTRY Machinist	
15. MOTHER'S MAIDEN NAME Mary E. Smith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. 2	
17. SOCIAL SECURITY NO. 220-05-1773		18. INFORMANT ADDRESS Myrtle W. Miller 1320 Maple Ave.	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.1 ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/13/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec. 16, 69	
24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Dorsey Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Ambrose Inc.		ADDRESS 1328 Sulphur Sp. Rd.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-534		69 12403		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12403	
1. NAME OF DECEASED (Type or Print) CLIFTON KENDALL				2. DATE AND HOUR OF DEATH December 13, 1969 11:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5615 Plymouth Road				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2706 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5615 Plymouth Road			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 5, 1895	9. AGE (In years lost birthday) 74	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10B. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal Co		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Kendall				14. MOTHER'S MAIDEN NAME Florence			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Harry W. Kendall, 1314 E. Belvedere Ave.			
18. 410191 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE Coronary thrombosis DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic C-V disease DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus (C) 20 yrs 7 yrs				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Nov. 27 19 50 to Dec. 13 , 19 69 , that (I) (we) last saw the deceased alive on Dec. 7 , 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE H. V. Harbold M.D.				23B. DATE SIGNED Dec. 14, 1969		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Harold V. Harbold, M.D.				23D. ADDRESS 4706 Harford Road.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/69		24C. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		24D. LOCATION (City, town, or county) (State) Rock Hall, Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Ulrich Funeral Home		ADDRESS 4210 Belair Road.	



i

69 12404

Baltimore City Health Department
CERTIFICATE OF DEATH

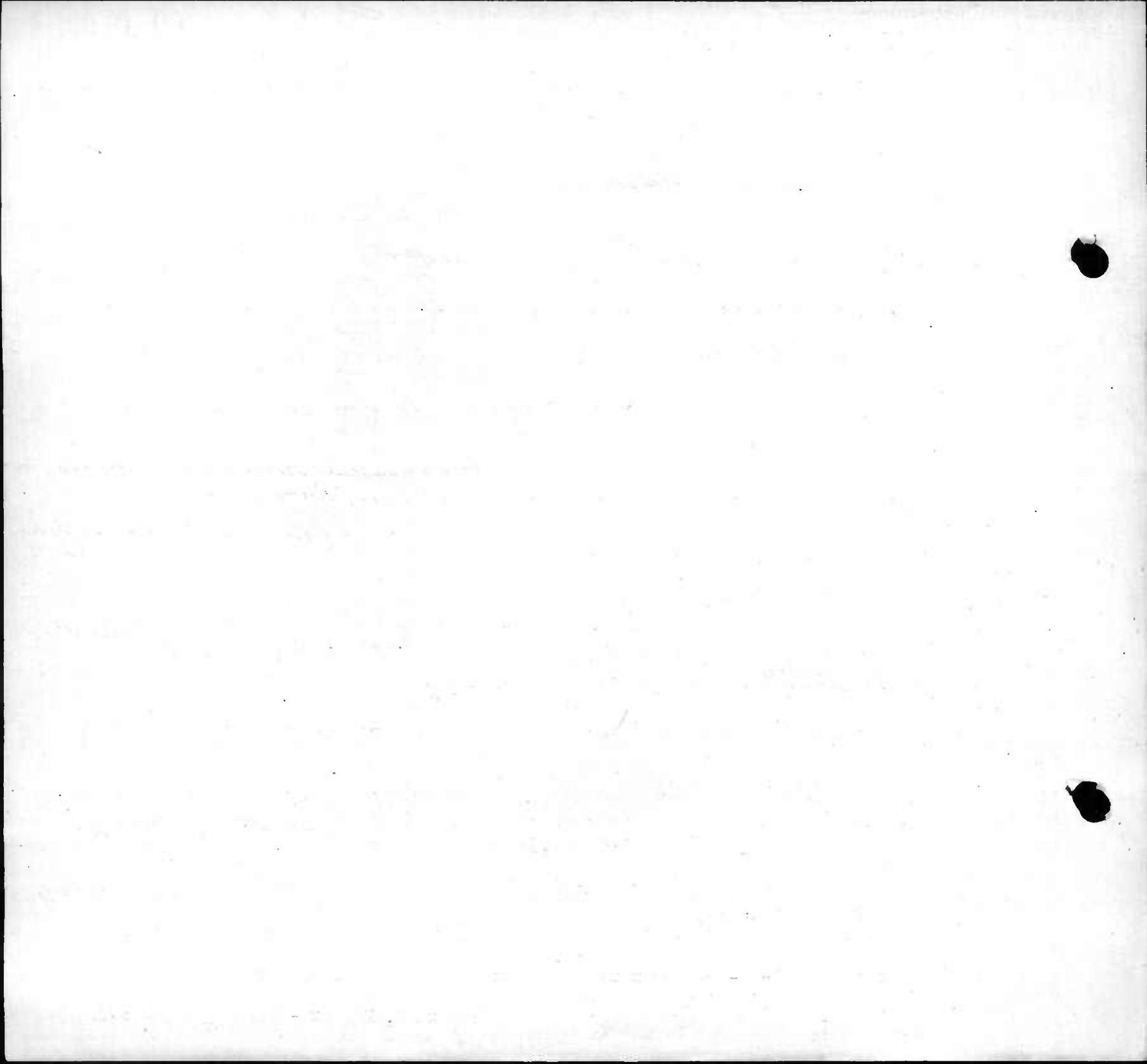
REG. NO.

69 12404

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

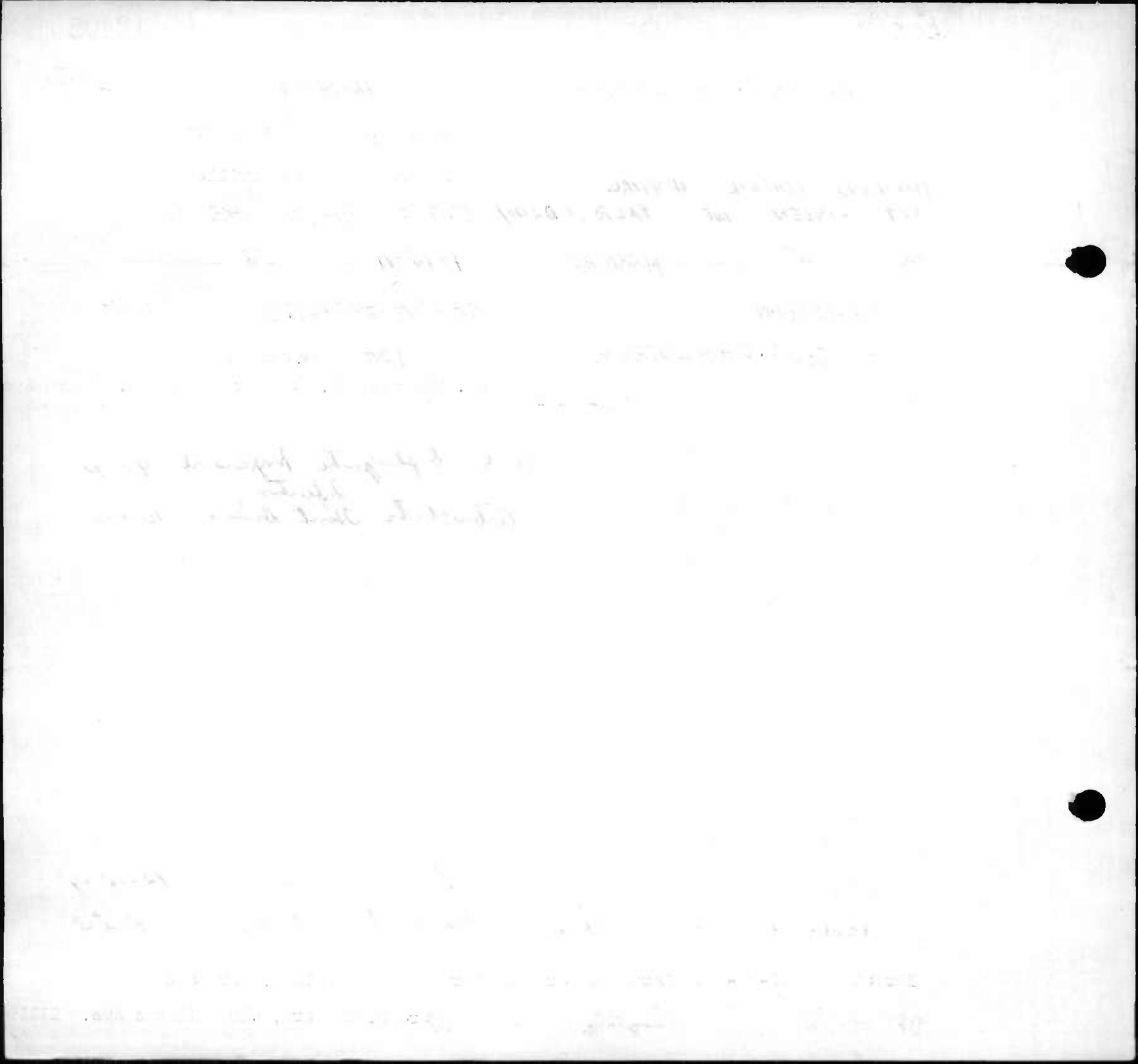
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		WILLIE B. WILHOLTE		12.14.69 9.50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY	
BON SECOURS HOSPITAL. 34				Md. 1902	
				C. CITY OR TOWN D. INSIDE CITY LIMITS?	
				BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER	
				35 S. CALHOUN STREET.	
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
M		W		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years lost birthday)		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
08/13/04		65			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY	
MACHINE OPERATOR					
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?	
KENTUCKY				USA.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME	
JOSEPH WILHOLTE				SARAH WILLIAMS	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.	
N/A				414-07-698	
17. INFORMANT				ADDRESS	
Patient's admission history					
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				12 hrs.	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES				Several years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
Cerebrovascular accident - probably Thrombosis					
(B) Generalized arteriosclerosis.					
(C) _____					
II				6 months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
Femoral by-pass grafting, graft removed. Leg, gangrene amputation and skin grafts - all for arteriosclerosis.					
19A. DATE OF OPERATION		19B. DATE WHEN OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
10-11, 10-31		10-23, 12-1/69		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., M or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
NO					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (1) (this hospital) attended the deceased from 09/19 19 69 to 12/14 19 69, that (1) last saw the deceased alive on 12/13 19 69 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
H. L. Caulfield M.D. Ch.B. DEGREE				12/14/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
H. L. Caulfield.				BON SECOURS HOSPITAL.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		12-17-69		Evergreen Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		ADDRESS	
Luray, Virginia		Howard H. Hubbard-4107 Wilkens Ave		Baltimore, Md. 21229	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>69 12405</p> <p>CERTIFICATE OF DEATH</p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p>	
<p>1. NAME OF DECEASED (Type or Print) WALTER G. PAHLSTROM</p>		<p>2. DATE AND HOUR OF DEATH 12-14-69 12:25 P.M.</p>	
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 827 LINDEN AVE. BALTO. MD 21201</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) XXXXXXXXXXXX Catonsville D. STREET ADDRESS (If rural, give location) 517 S. HILTON AVE</p>	
<p>5. SEX M</p>	<p>6. RACE W</p>	<p>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED</p>	<p>8. DATE OF BIRTH 1-18-11</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES MAN</p>		<p>11. BIRTHPLACE (State or foreign country) MASSACHUSETTS</p>	<p>12. CITIZEN OF WHAT COUNTRY? USA</p>
<p>13. FATHER'S NAME GUSTAV P. DAHLSTROM</p>		<p>14. MOTHER'S MAIDEN NAME IDA NIELSON</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 212-01-6095</p>	<p>17. INFORMANT Mrs. Elizabeth K. Dahlstrom, 517 S. Hilton Ave WIFE - ELIZABETH DAHLSTROM - Jane</p>
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.9 I Acute Diphtheritic Infection</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>CAUSE OF DEATH Acute Diphtheritic Infection Arteriosclerotic Heart Disease</p> <p>INTERVAL BETWEEN ONSET AND DEATH 9 days 10 mos</p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>			
<p>19A. DATE OF OPERATION 12-16-69</p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No) No</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 12-14-69 to 12-14-69, that (I) (we) last saw the deceased alive on 12-14-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <i>Angelita A. Topacio</i></p>		<p>23B. DATE SIGNED 12-14-69</p>	<p>23C. PHYSICIAN'S NAME (Type) ANGELITA A. TOPACIO</p>
<p>23D. ADDRESS Maryland General Hospital</p>		<p>23E. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>	<p>24B. DATE 12-16-69</p>	<p>24C. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery</p>	<p>24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland</p>
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969</p>		<p>25B. NAME OF REGISTRAR Robert E. Taylor</p>	



S-452

69 12406

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12406

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Carl A. Schilling		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 13 69 1:55 p. m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2541	
9. DATE OF BIRTH 2-25-1906		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Schilling		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	
15. MOTHER'S MAIDEN NAME Amelia Trup		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes W W II	
17. SOCIAL SECURITY NO. 215-07-0317		18. INFORMANT ADDRESS Miss Olga Schilling, 733 S. Woodington Rd. 21229	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Werner U. Spitz, M.D. M.D. DATE SIGNED: 12/14/69 EXAMINER'S NAME (Type): Werner U. Spitz, M.D. Deputy Chief Medical Examiner			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-17-1969	
24C. NAME OF CEMETERY or CREMATORY Balto. National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	

NO. 100

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NO. 100

100

ADDITIONAL

[Handwritten signature]

B-600

69 12407

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12407

BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> December 11, 1969		Hour	
		WILLIAM BIER				M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year December 11, 1969		Hour		1:05 P.M.	
1409 N. Patterson Park Avenue		5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland		B. COUNTY 804			
6. SEX Male	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 10-31-1881	10. AGE (In years last birthday) 88	11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME UNKNOWN	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER		14B. KIND OF BUSINESS OR INDUSTRY PUBLIC SCHOOL		15. MOTHER'S MAIDEN NAME UNKNOWN			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT WIFE - RUTH BIER		ADDRESS SAME	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: December 11, 1969							
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/15/69		24C. NAME OF CEMETERY or CREMATORY LORRAINE PK.		24D. LOCATION (City, town, or county) (State) BALTO - WOODLAWN - MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR R. E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. J. Fickner & Sons, Baltimore		ADDRESS	

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UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

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NOV 10 1964

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UNITED STATES DEPARTMENT OF JUSTICE

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WASHINGTON, D. C. 20530

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OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

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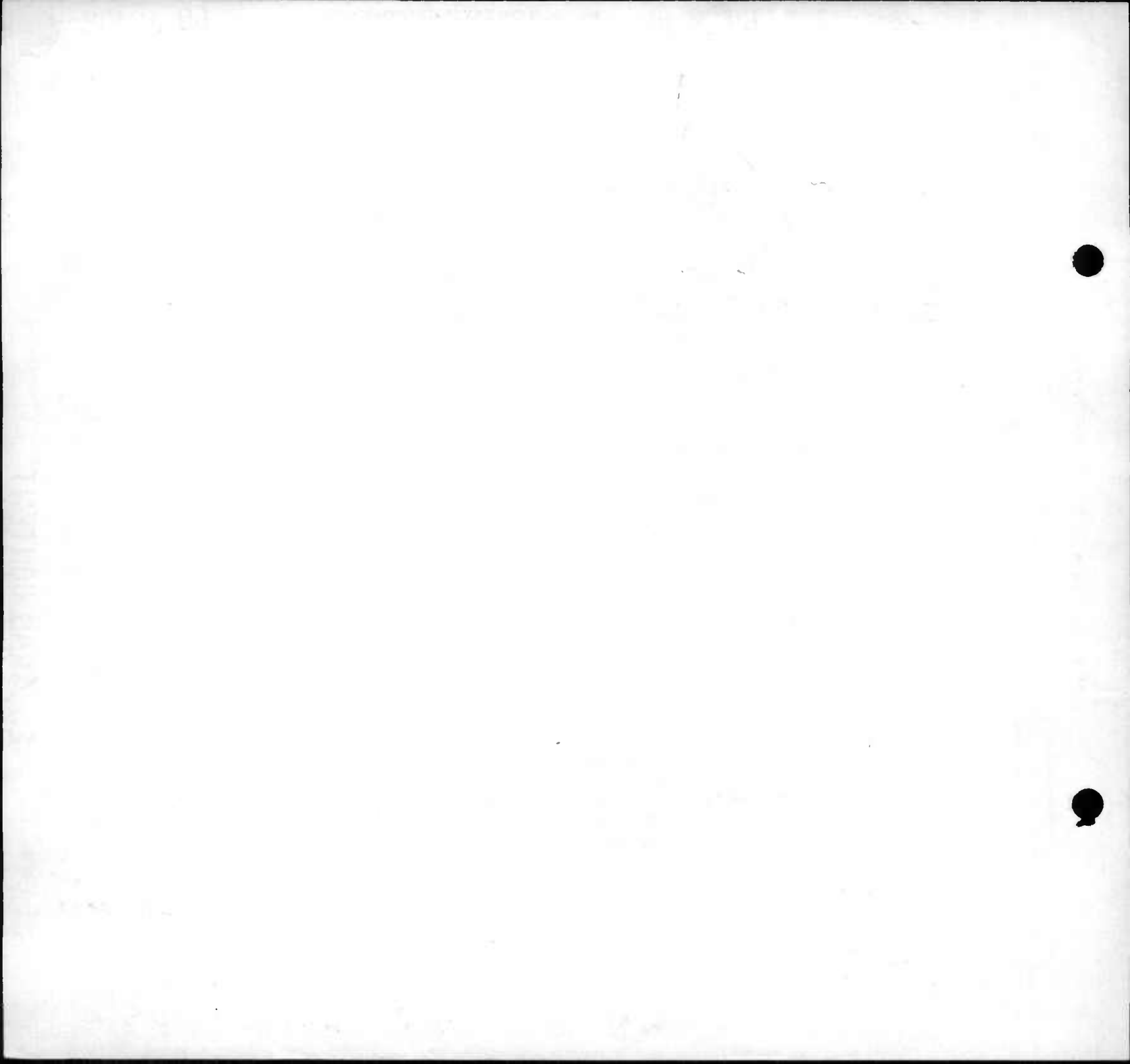
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-536 69 12408		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12408	
BIRTH NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANDRAE, CLARA		12/8/69 10 45 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Md 1206			
HARFORD GARDENS NURSING HOME		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
		D. STREET ADDRESS (If rural, give location)		3006 CRESMENT AVE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. CITIZEN OF WHAT COUNTRY?
F	W	Never Married	12/24/78	90 yrs	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
EMBROIDER		CLOTHING		MD.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		214-26-6240			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		5 months	
ANTECEDENT CAUSES		(B) DUE TO		2 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1968 to Dec. 8 1969, that (I) (we) last saw the deceased alive on Dec. 7 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
DR. LOY ZIMMERMAN				12/11/69	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
DR. LOY ZIMMERMAN				3202 HARFORD Rd. Balto. Md	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
BURIAL		12-12-69		LOUDON PK.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 16 1969		Jesse J. Baker		WM J. STRICKNER & SONS	



FUNERAL DIRECTOR: IMPORTANT

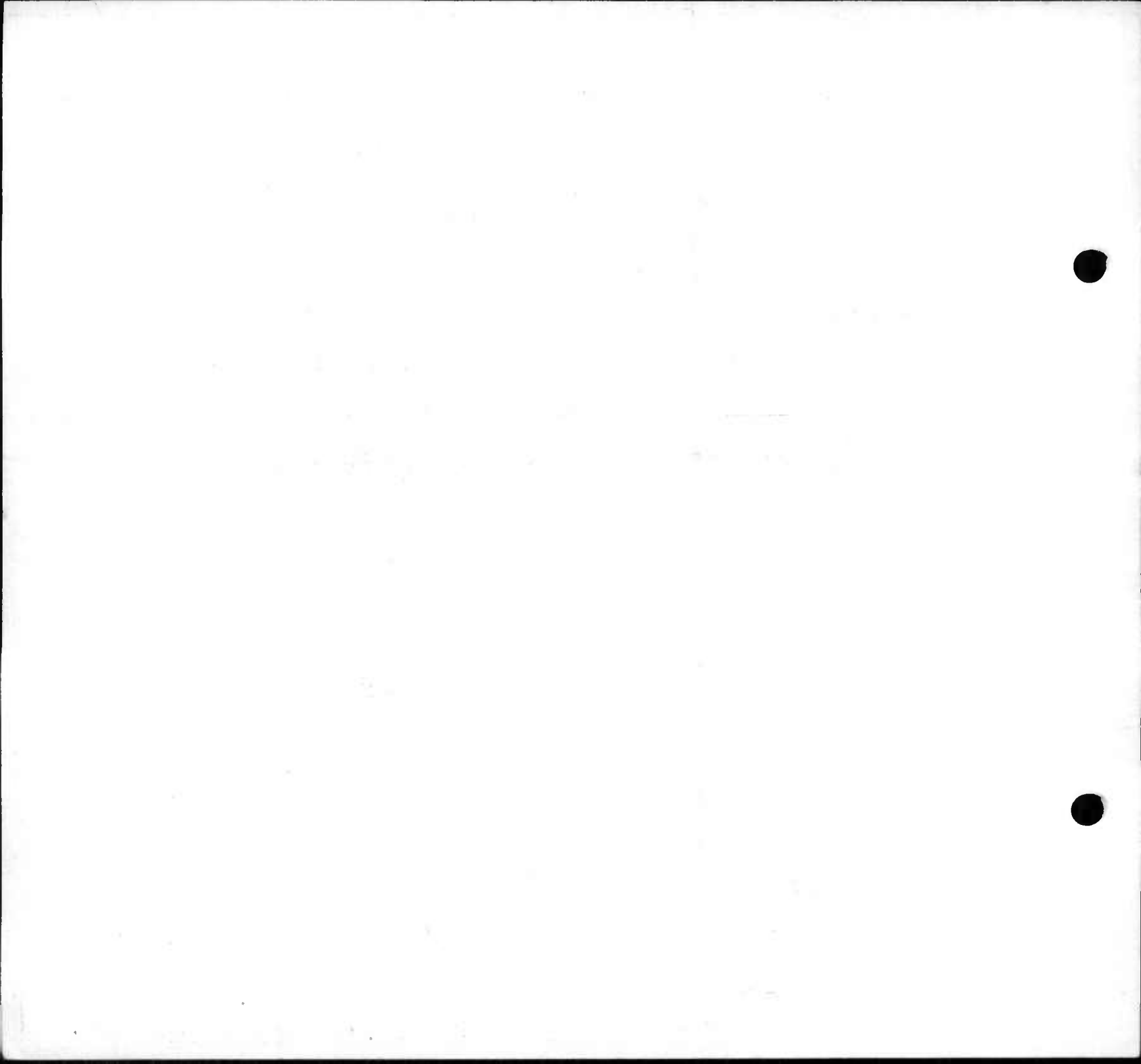
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 69 12409	
1. NAME OF DECEASED (Type or Print) LEUTBECKER, ELIZABETH MAY		2. DATE AND HOUR OF DEATH 12/10/69 8⁴⁰ P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GENERAL HOSPITAL 48		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTO. 1701 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 305 W MARION ST.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED		8. DATE OF BIRTH 5-11-1903	9. AGE (In years last birthday) 66
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES LADY		10B. KIND OF BUSINESS OR INDUSTRY RETAIL STORE		11. BIRTHPLACE (State or foreign country) LANCASTER PA.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WALTER FRIEND		14. MOTHER'S MAIDEN NAME ELLA RITTENHOUSE			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS A - Hemothorax, R, massive.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 441.1 I ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH A - Rupture of aneurysm of Thoracic aorta - hours B - Arteriosclerotic heart disease C - Aortic		INTERVAL BETWEEN ONSET AND DEATH years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 12ec 10 1969 to Dec 10 1969, that (I) last saw the deceased alive on Dec 10 1969 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (the) (did) (did not) view the body after death.					
23A. SIGNATURE Frank N. Turner M.D.				23B. DATE SIGNED 12/10/69	
23C. PHYSICIAN'S NAME (Type) FRANK N. TURNER				23D. ADDRESS 54 A Z BEECH DRIVE, MIDDLE RIVER MD	
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-13-69		24C. NAME of CEMETERY or CREMATORY DRUID RIDGE	
24D. LOCATION (City, town, or county) (State) PIKESVILLE, MD.		25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969			
25B. NAME OF REGISTRAR Robert E. Tabor		25C. FUNERAL DIRECTOR ADDRESS Wm. S. DICKEY & SONS NAPA AVES BALD. MD. 21217			

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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>69 12410</p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p>CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12410</p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) IDA J. DUNCAN</p>		<p>2. DATE AND HOUR OF DEATH</p> <p>12-10-69 11:55 A.M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MARYLAND GEN. HOSPITAL</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2749</p> <p>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER 1527 Partridge Rd.</p>	
<p>5. SEX F</p>	<p>6. RACE W.</p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH 2-8-11</p>
<p>9. AGE (In years last birthday) 92</p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife</p>	<p>11. BIRTHPLACE (State or foreign country) MARYLAND</p>
<p>10A. KIND OF BUSINESS OR INDUSTRY Home</p>		<p>12. CITIZEN OF WHAT COUNTRY? USA</p>	
<p>13. FATHER'S NAME FRANK Bulter DUNCAN</p>		<p>14. MOTHER'S MAIDEN NAME XXXXXX Elizabeth Bell</p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>16. SOCIAL SECURITY NO. 212-18-3110</p>	<p>17. INFORMANT ADDRESS DAUGHTER - ESTHER TRACEY same</p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) GRANULOMATOUS COLITIS</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE PARTIAL INTESTINAL OBSTRUCTION YEARS DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>			
<p>19A. DATE OF OPERATION 0</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE</p>	
<p>20A. AUTOPSY? (Yes or No) NONE</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from 11-12-1969 to 12-10-1969 that (I) (we) last saw the deceased alive on 12-10-1969 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE Angelita A. Topacio</p>		<p>23B. DATE SIGNED 12-10-69</p>	
<p>23C. PHYSICIAN'S NAME (Type) ANGELITA A. TOPACIO</p>		<p>23D. ADDRESS MARYLAND GEN. HOSP.</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>24B. DATE 12-13-69</p>	
<p>24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park</p>		<p>24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland</p>	
<p>25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969</p>		<p>25B. NAME OF REGISTRAR Robert E. Fisher, M.D.</p>	
<p>25C. FUNERAL DIRECTOR William E. Johnson</p>		<p>ADDRESS 8521 Loch Raven Blvd. Baltimore Balto 21204</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12411	
BIRTH NO. 5-562 69 12411		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) THERESA M. SOMMERS		2. DATE AND HOUR OF DEATH December 14, 1969	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2534 Foster Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 103 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2534 Foster Avenue	
5. SEX Female	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1902
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 67
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Banackiewicz		14. MOTHER'S MAIDEN NAME Agnes Pokorska	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Milton L. Sommers ADDRESS 2534 Foster Avenue
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) Acute Coronary Occlusion ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis Sclerotic (B) DUE TO, OR AS A CONSEQUENCE OF: Hypertension CVD. (C) Bronchial Asthma		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 19 48 to Dec. 14 19 69 , that (I) (we) last saw the deceased alive on Dec. 13 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.			
23A. SIGNATURE Melvin J. Jaworski		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED 12/15/69
23C. PHYSICIAN'S NAME (Type) M. J. JAWORSKI M.D.		23D. ADDRESS 2711 Eastern Ave Balto Ind.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-17-1969	24C. NAME OF CEMETERY or CREMATORY Oak Lawn	24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor M.D.	25C. FUNERAL DIRECTOR Malby & Zeiler Inc. ADDRESS 1901-07 Eastern Ave.

John Henry Cartwright

London, England
September 11, 1851
Dear Sir

Yours very truly

J. H. Cartwright

10, Abchurch Lane
London, E.C. 4

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

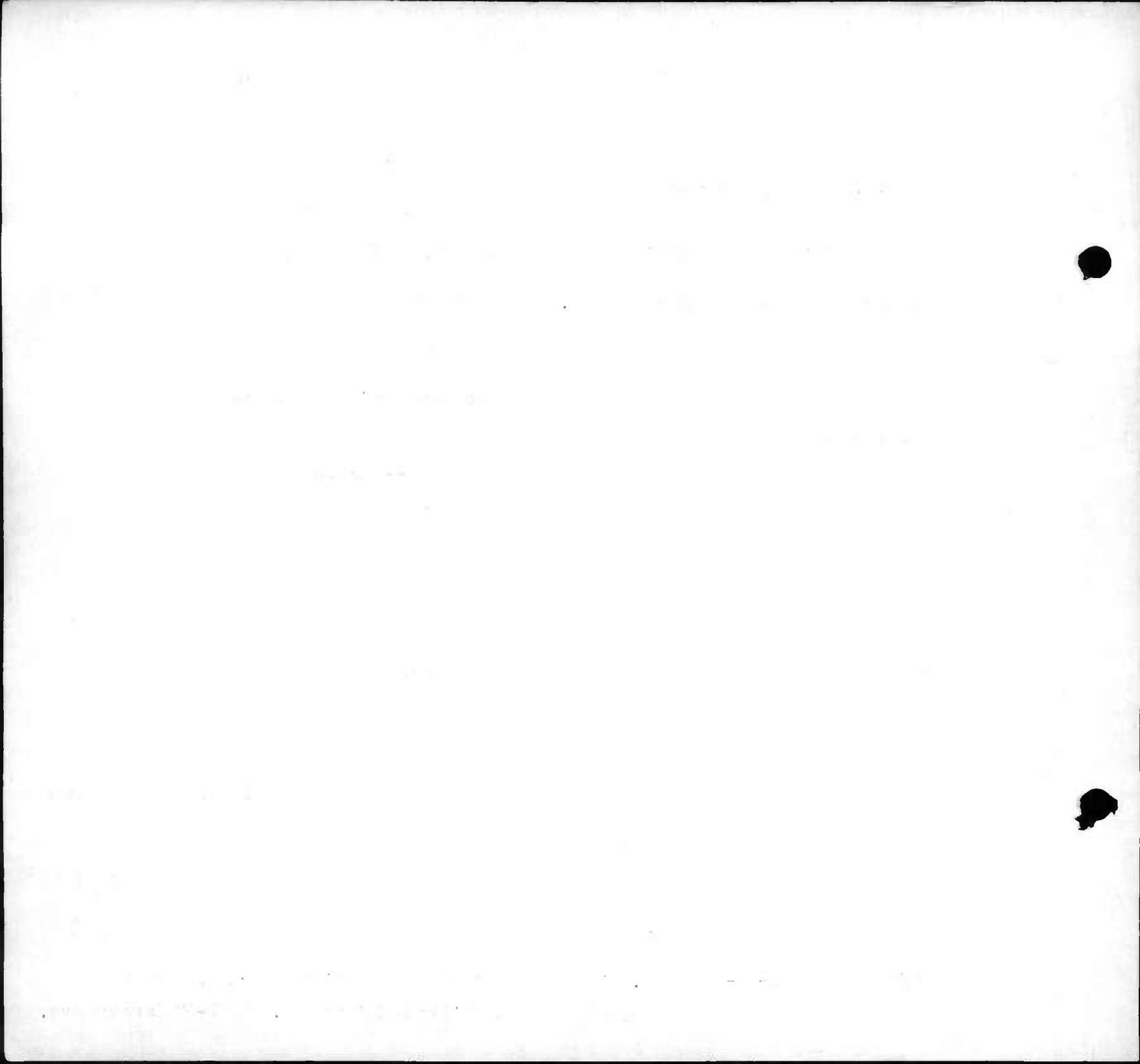
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12412	
H-200 69 12412				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FRANCES HOUCK		December 11, 1969 10:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
31 Baltimore City Hospital			Maryland		
			C. CITY OR TOWN		D. INSIDE CITY LIMITS?
			Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER		
			820 S. East Avenue		
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years)
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	April 17, 1914		35
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
File Clerk & Typist				Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Paul Benke			Theresa Palczynski		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Miss Marie Benke 820 S. East Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
412.2 I			Hypertensive arteriosclerotic Cardio-		
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE		
			DUE TO, OR AS A CONSEQUENCE OF		
			Vascular disease		
ANTECEDENT CAUSES			(B) Arteriosclerosis		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
			(C) _____		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At <input type="checkbox"/> Work Not While At <input type="checkbox"/> Work			
22. I certify that (I) (this hospital) attended the deceased from August 5, 1968 to November 15, 1969, that (I) (we) last saw the deceased alive on November 15, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Melito M. Torres, M. D.				December 12, 1969	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
441 S. ELLWOOD AVENUE					
BALTIMORE, MARYLAND					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE OF BURIAL CREMATION, REMOVAL		24C. CEMETERY or CREMATORY	
Burial		12-15-1969		Sacred Heart	
				Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
DEC 16 1969		John E. Talbot, M.D.		Lilly & Zeller Inc. 1901-07 Eastern Ave.	

THE
STATION
AND
OFFICE
OF
THE
SHERIFF
OF
THE
COUNTY
OF
SHERBORN
MASSACHUSETTS
JANUARY 10 1900

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1-220 69 12413		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 69 12413	
1. NAME OF DECEASED (Type or Print)		WASYL LUCIAK		2. DATE AND HOUR OF DEATH December 11, 1969 11 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 203 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2027 Fleet Street			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH June 1, 1917	9. AGE (In years last birthday) 52	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter Helper		10B. KIND OF BUSINESS OR INDUSTRY Owens Boat Co.		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? Poland		13. FATHER'S NAME			
14. MOTHER'S MAIDEN NAME Anna		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs Anna Luciak 2027 Fleet Street			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Perforated duodenal ulcer</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH —	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 1953 to Dec. 8 1969, that (I) (we) last saw the deceased alive on Dec. 8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Sigmund R. Nowak		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED Dec. 12, 1969	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS SIGMUND R. NOWAK M.D. 408 S. Patterson Ph. An. Baltimore, Md. 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-1969		24C. NAME OF CEMETERY or CREMATORY St. Michael Ukrainian	
24D. LOCATION Baltimore County, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969			
25B. NAME OF REGISTRAR Lilly & Zeiler Inc.		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901-07 Eastern Ave.			



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R-000

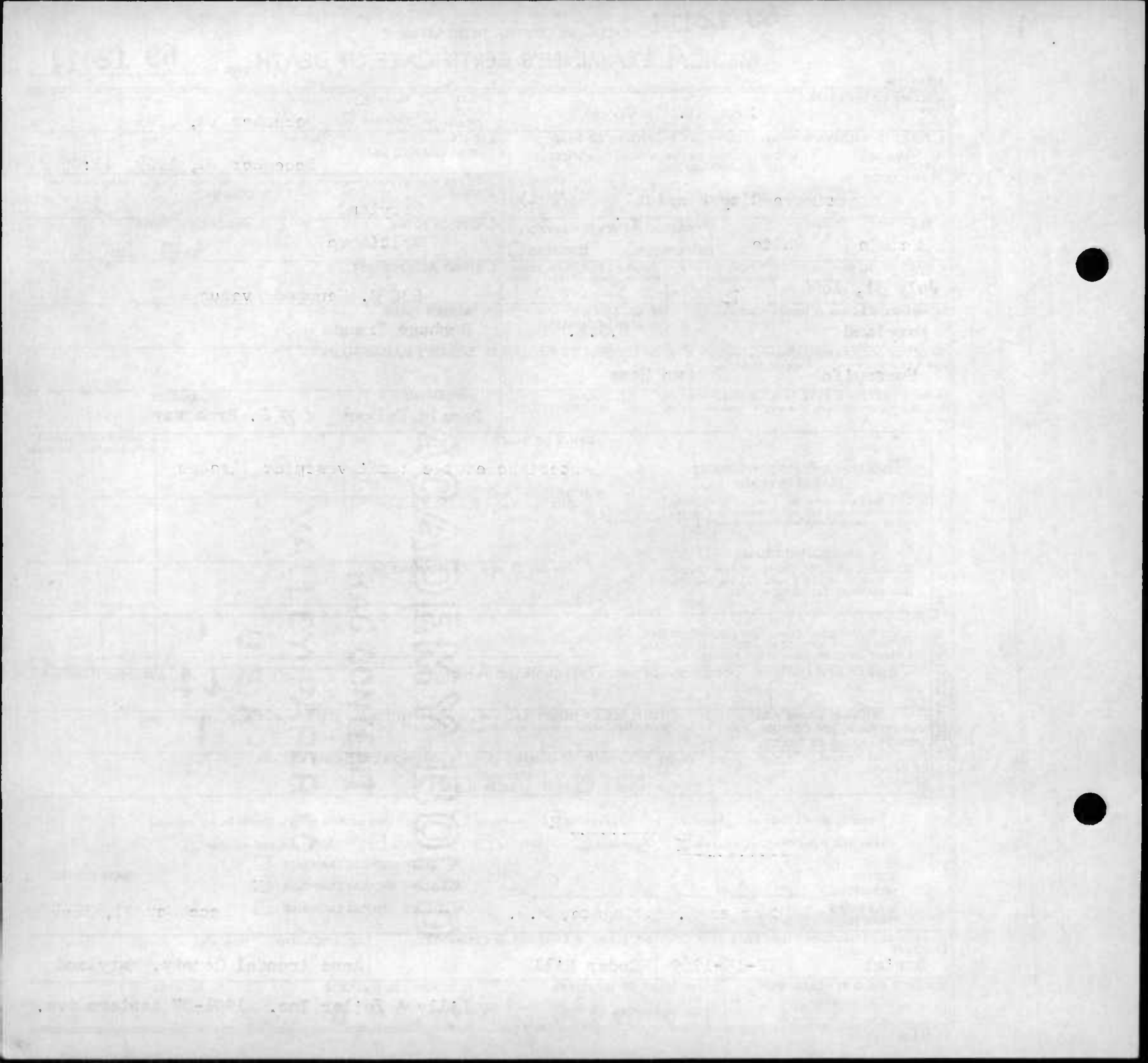
69 12414

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12414

BIRTH NO.		1. NAME OF DECEASED (Type or Print) CORA A. ROWE		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour December 10, 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour December 10, 1969 11:00 P.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 104	
6. SEX Female	7. RACE White	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH July 31, 1894		10. AGE (In years last birthday) 75		E. STREET AND NUMBER 838 S. Kenwood Avenue	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF U.S.A.		13. FATHER'S NAME Burbage Trnum	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		14B. KIND OF BUSINESS OR INDUSTRY Own Home		15. MOTHER'S MAIDEN NAME	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT Ronald Walker	
				ADDRESS 609 S. Broadway	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: Charles S. Springate, M.D. EXAMINER'S NAME (Type): Charles S. Springate, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: December 11, 1969					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-1969		24C. NAME OF CEMETERY or CREMATORY Cedar Hill	
24D. LOCATION (City, town, or county) (State) Anne Arundel County, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Lilly & Zeller Inc.		25D. ADDRESS 1901-07 Eastern Ave.			



S-436

69 12415 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12415

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) Milton E. Schluter		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month 12 Day 12 Year 69 Hour M. Estimated <input type="checkbox"/>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 9 N. Kresson St. (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month 12 Day 12 Year 69 Hour 7:05 p.m.	
6. SEX male		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2664	
7. RACE white	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Mar. 23, 1900	10. AGE (In years last birthday) 69	E. STREET AND NUMBER 9 N. Kresson St. # 21224.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Ernest Schluter	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	14B. KIND OF BUSINESS OR INDUSTRY Carpenter	15. MOTHER'S MAIDEN NAME Julia Naumann	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	17. SOCIAL SECURITY NO. 212-16-5731	18. INFORMANT ADDRESS Mrs. Lillian Benner Same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). bronchiectasis and emphysema		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 12-15-69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/13/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-15-69	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) 4430 Belair Rd., Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor	
25C. FUNERAL DIRECTOR Robert E. Taylor		25D. ADDRESS 901 S. Conkling St. Balto., 21224, Md.	

10 12 13

THE EXAMINER'S CERTIFICATE OF ANALYSIS

ANALYSIS OF THE SAMPLE SUBMITTED BY THE FOLLOWING PARTY

NAME OF THE PARTY SUBMITTING THE SAMPLE

ANALYST

DATE

PLACE

ANALYSIS OF THE SAMPLE SUBMITTED BY THE FOLLOWING PARTY

NAME OF THE PARTY SUBMITTING THE SAMPLE

ANALYST

DATE

PLACE

ANALYSIS OF THE SAMPLE SUBMITTED BY THE FOLLOWING PARTY

NAME OF THE PARTY SUBMITTING THE SAMPLE

ANALYST

DATE

PLACE

ANALYSIS OF THE SAMPLE SUBMITTED BY THE FOLLOWING PARTY

NAME OF THE PARTY SUBMITTING THE SAMPLE

ANALYST

DATE

PLACE

ANALYSIS OF THE SAMPLE SUBMITTED BY THE FOLLOWING PARTY

NAME OF THE PARTY SUBMITTING THE SAMPLE

ANALYST

DATE

PLACE

ANALYSIS OF THE SAMPLE SUBMITTED BY THE FOLLOWING PARTY

NAME OF THE PARTY SUBMITTING THE SAMPLE

ANALYST

DATE

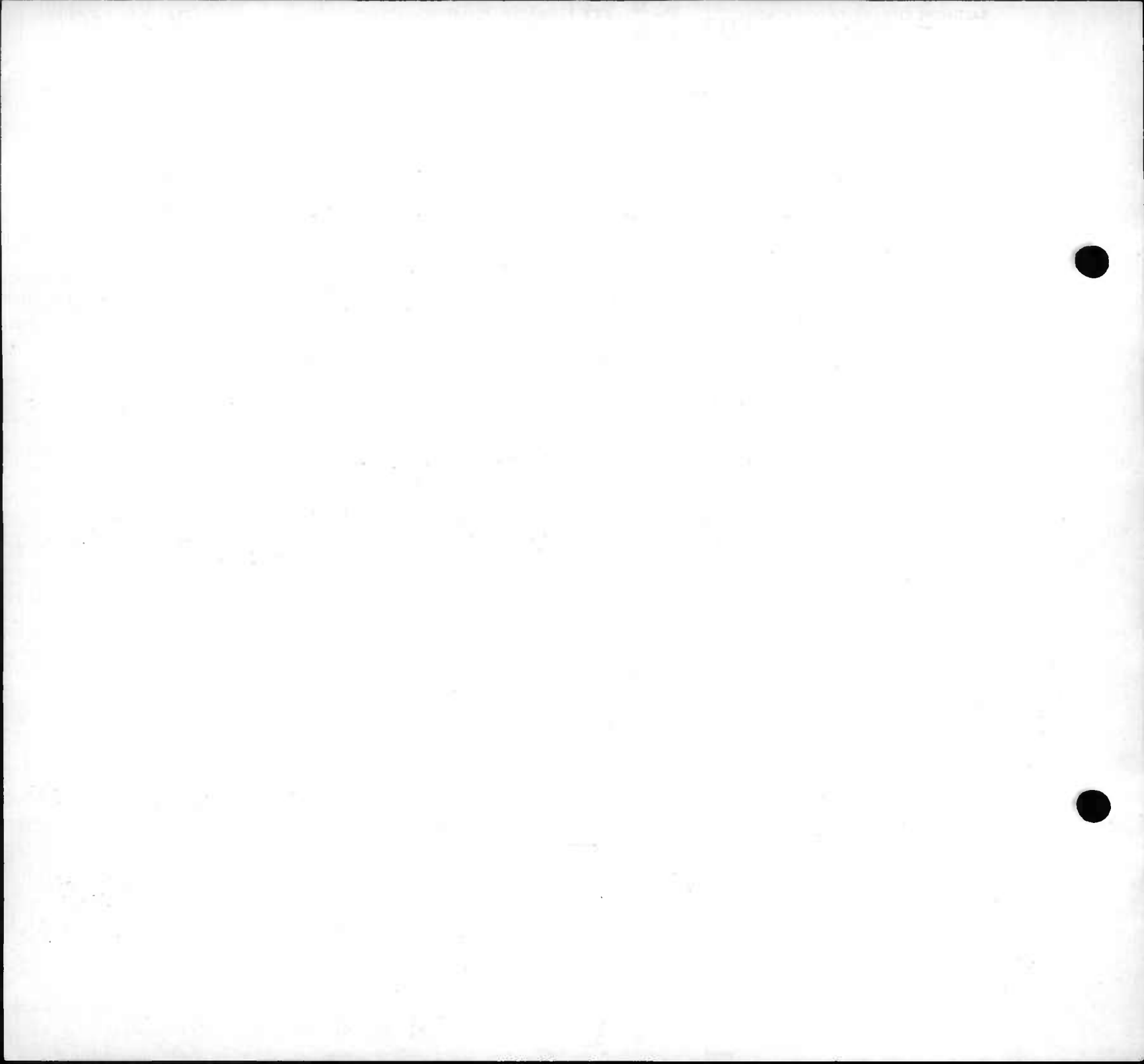
PLACE

ANALYSIS OF THE SAMPLE SUBMITTED BY THE FOLLOWING PARTY

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

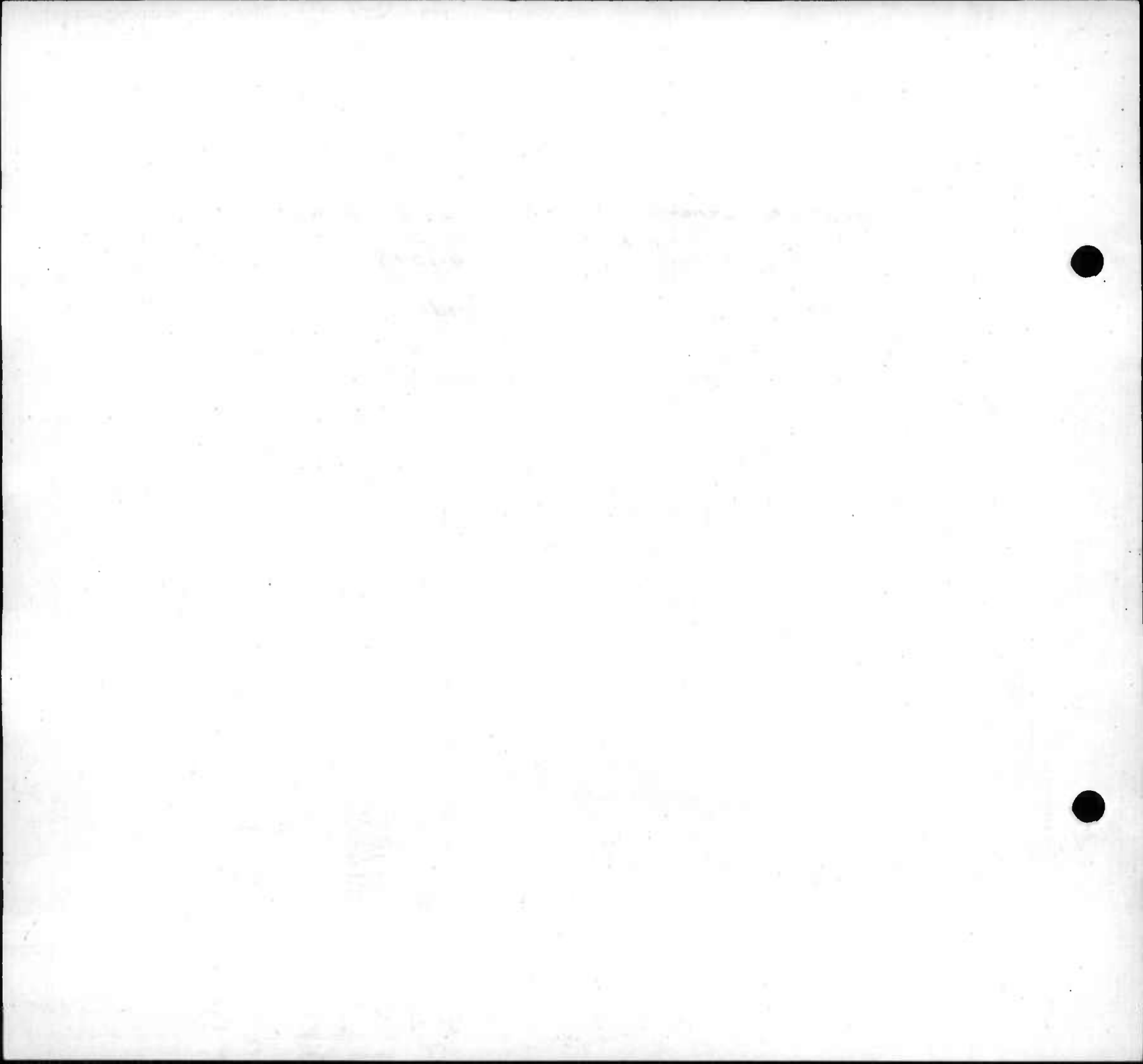
H-220		69 12416		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12416	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) John Husak			
2. DATE AND HOUR OF DEATH 12-13-69 9:20 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1456 Decatur St. Baltimore, Md. 21230			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2401		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 1456 Decatur St.	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/12/14	9. AGE (In years last birthday) 55	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electric Repairman		10B. KIND OF BUSINESS OR INDUSTRY Hammonds Music Store		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John Husak				14. MOTHER'S MAIDEN NAME N.Y. Known			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 213-03-4832		17. INFORMANT Mrs. Genevieve Husak 1456 Decatur St.			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) Coronary thrombosis - 1/2 hr. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Atherosclerosis - 15 yrs. Heart disease II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from Nov 13 1964 to Dec 13 1969, that (I) (we) last saw the deceased alive on Dec 8 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE Norman R. Freeman				23B. DATE SIGNED 12/15/69		23C. PHYSICIAN'S NAME (Type) NORMAN R. FREEMAN JR.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/69		24C. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Charles E. Stevens Funeral Home, Inc. 905 E. Fort Avenue		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

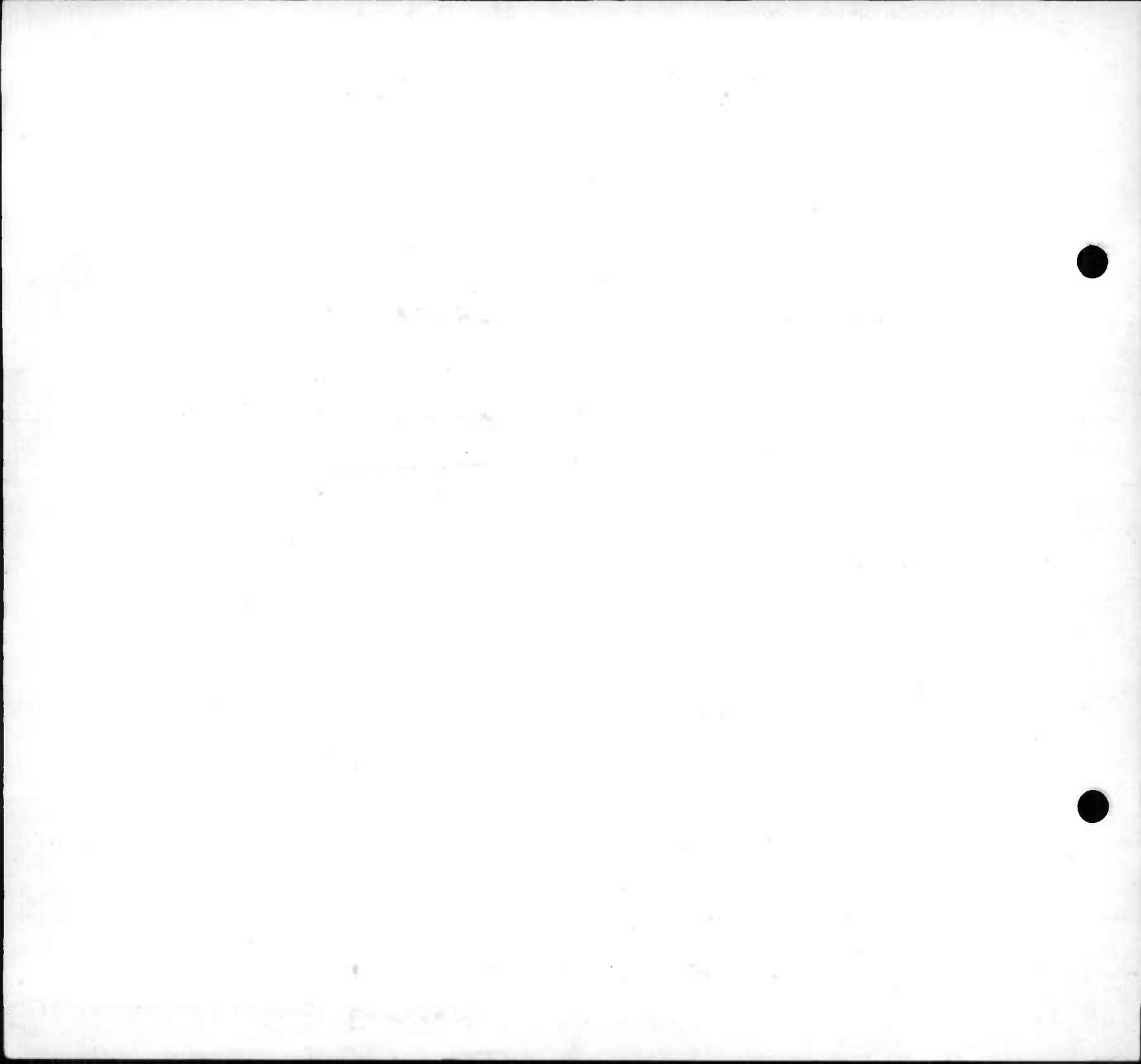
E-165		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12417	
BIRTH NO. 69 12417		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ELBURN, James W. R.			2. DATE AND HOUR OF DEATH 12-13-69 1144 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 43 South Balto General Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 2401 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 149 E. Clement St		
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-13	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) machinist		10B. KIND OF BUSINESS OR INDUSTRY Maryland Drydock		11. BIRTHPLACE (State or foreign country) md.	
13. FATHER'S NAME Russell Elburn			14. MOTHER'S MAIDEN NAME N. K. K. K.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 228-16-4444		17. INFORMANT ADDRESS Martha Elburn 1419 East Clement St.	
18. 291.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebrovascular Accident (B) DT; Septicemic Pneumonia (C) Ruptured Peptic Ulcer		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/1 1969 to 12/13 1969, that (I) (we) last saw the deceased alive on 12/13 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE A. Villafania MD 23C. PHYSICIAN'S NAME (Type) ARTEMIO A. VILLAFANIA				23B. DATE SIGNED 12/13/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/16/69		24C. NAME OF CEMETERY OR CREMATORY Glen Haven Memorial Park	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR L. Stevens Funeral Home, Inc. 1501 East Fort Avenue	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-6201		69 12418		CITY HEALTH DEPARTMENT		REG. NO. 599		69 12418	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>PARRIS, James</i>				2. DATE AND HOUR OF DEATH <i>12/13/69</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MD</i> B. COUNTY <i>Harford</i>				5. SEX <i>M</i> 6. RACE <i>C</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Harbor View H.C.C.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>1130 Light St</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <i>1022 W. Banne St 2101</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>?</i>		11. BIRTHPLACE (State or foreign country) <i>South Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		9. AGE (In years last birthday) <i>54</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>220057010</i>		17. INFORMANT <i>Jeannette Stewart</i>	
18. <i>162.1</i> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <i>Bronchogenic Carcinoma</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>?</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(B) <i>Metastases to Brain</i>				(C) <i>?</i>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <i>12/8/69</i> to <i>12/12/69</i> , that (I) (we) last saw the deceased alive on <i>12/8/69</i> and that in (my) (our) opinion a death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <i>Joseph S. Blum</i>			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23B. DATE SIGNED <i>12/13/69</i>		23E. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-17-69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Baltimore National</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 16 1969</i>		25B. NAME OF REGISTRAR <i>John E. Fisher</i>		25C. FUNERAL DIRECTOR <i>Charles G. Rice</i>		25D. ADDRESS <i>661 W. Banne ST.</i>			



69 12419 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12419

BIRTH NO.

1. NAME OF DECEASED (Type or Print) SAMUEL (BULIPS) BILUPS		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 903 Ridgely St. (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 15 69 5:55 A.M.	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2101			
6. SEX Male ;	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 7-16-16	10. AGE (In years lost birthday) 53	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	E. STREET AND NUMBER 903 Ridgely St.
11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Seymour Bilups	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Blanche			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes		17. SOCIAL SECURITY NO. 224-01-6045	
18. INFORMANT Paulene Bilups		ADDRESS 3701 Towanda Ave.	
19. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Russell S. Fisher</u> M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 12-15-69 EXAMINER'S NAME (Type) Russell S. Fisher, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-19-69	
24C. NAME OF CEMETERY or CREMATORY Baltimore, National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	

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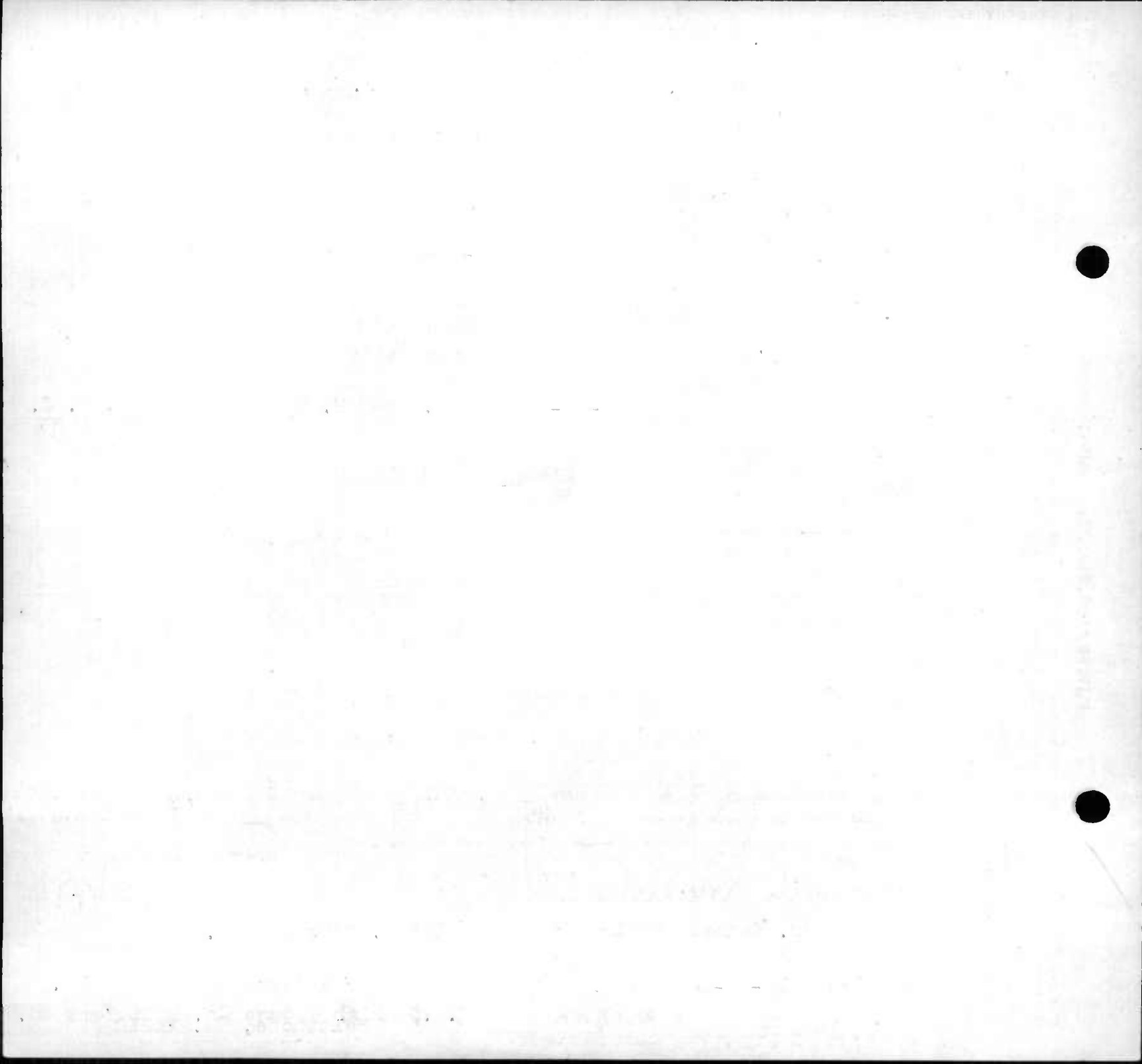
10/10/1991

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10/10/1991

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

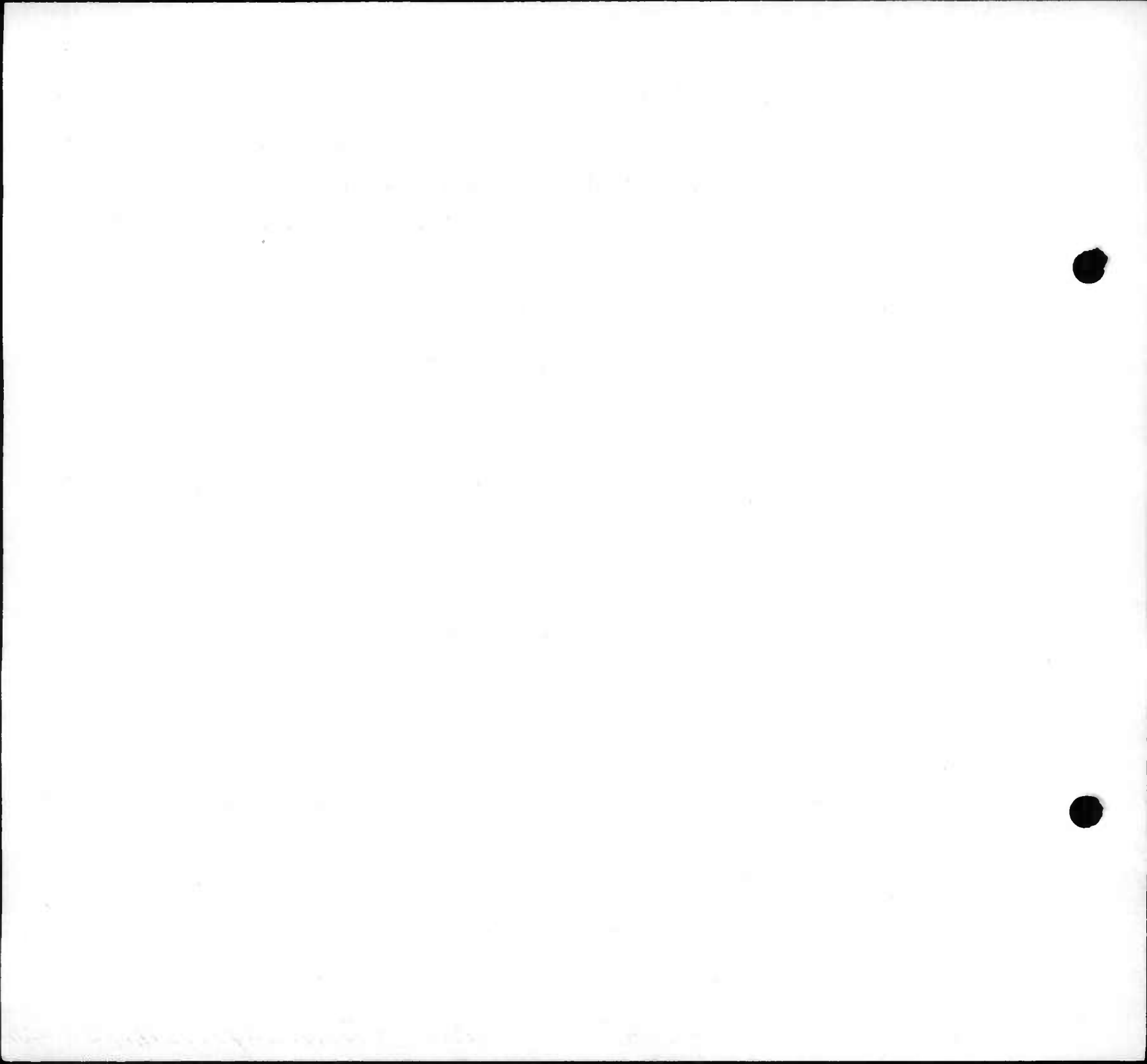
VS 150-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

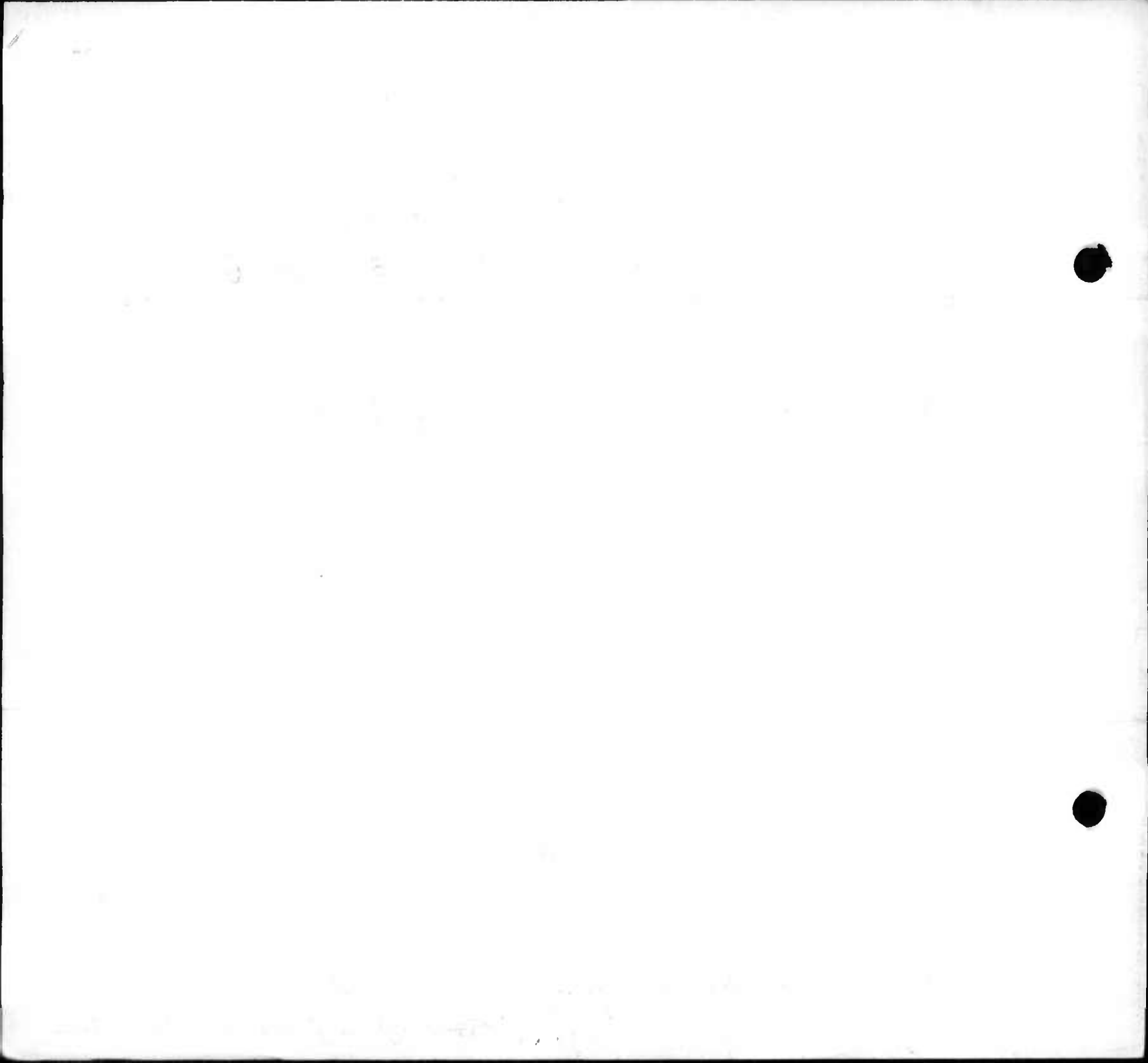
M-320		69 12421		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12421	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Thomas E. Matthews Sr</i>				2. DATE AND HOUR OF DEATH <i>12 Dec 69 8:15 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital of Baltimore</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>3911 Wash Ave 21215</i>							
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/2/13</i>	9. AGE (In years lost birthday) <i>56</i>	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Postal Clerk</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Edward Matthews</i>				14. MOTHER'S MAIDEN NAME <i>Clara V. Proams</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>218-09-3477</i>		17. INFORMANT <i>Lucille Matthews</i>		ADDRESS <i>Same</i>	
18. <i>431.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>Intracerebral Hemorrhage</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Intracerebral Hemorrhage</i>			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <i>Cirrhosis of Liver</i>							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (this hospital) attended the deceased from <i>8 Dec 1969</i> to <i>12 Dec 1969</i> that (we) last saw the deceased alive on <i>12 Dec 1969</i> and that (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (not) view the body after death.							
23A. SIGNATURE <i>Morris Ostroff MD</i>				23B. DATE SIGNED <i>12 Dec 1969</i>			
23C. PHYSICIAN'S NAME (Type) <i>Morris Ostroff MD</i>				23D. ADDRESS <i>Sinai Hospital of Baltimore</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12/16/69</i>		24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 16 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Fisher MD</i>		25C. FUNERAL DIRECTOR <i>Wilmington, Delaware 17271</i>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-130		69 12422		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12422	
1. NAME OF DECEASED (Type or Print) CHEVATT, MORRIS					2. DATE AND HOUR OF DEATH 5 ⁴⁵ PM 12-13-69 5 ³⁰ PM				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL of BALTIMORE					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3708 MORTIMER Ave.				
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/13/83	9. AGE (In years last birthday) 86	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		11. BIRTHPLACE (State or foreign country) Russia	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.		17. INFORMANT Hosp chart ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 491X I CHRONIC OBSTRUCTIVE LUNG DISEASE DUE TO, OR AS A CONSEQUENCE OF: EMPHYSEMA + CHRONIC BRONCHITIS DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CONGESTIVE HEART FAILURE					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
19A. DATE OF OPERATION D		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (we) (this hospital) attended the deceased from 12-11-69 19 to 12-13-69 19 that (we) last saw the deceased alive on 12-13-69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.									
23A. SIGNATURE M. Bodenheim					23B. DATE SIGNED 12-13-69			23C. PHYSICIAN'S NAME (Type) M. BODENHEIMER	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 12/14/69			24C. NAME OF CEMETERY or CREMATORY Beth Jacob Ansh Vesel	
25A. DATE REC'D BY HEALTH DEPT. DEC 16 1969					25B. NAME OF REGISTRAR Robert E. Taylor, Md.			25C. FUNERAL DIRECTOR Sylvia Lewis & Son 9610 Reisterstown	



S-2010

69 12423

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

69 12423

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

MANUEL CACHO-SOUSA

2. DATE AND HOUR OF DEATH

12-16-69

2:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

THE JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE
PERU

B. COUNTY

C. CITY OR TOWN

LIMA

D. INSIDE CITY LIMITS?

YES ☐NO ☒

E. STREET AND NUMBER

AV. GENERAL SANTA CRUZ

737

5. SEX

MALE

6. RACE

WHITE

7. MARRIED ☒NEVER MARRIED ☐WIDOWED ☐DIVORCED ☐

8. DATE OF BIRTH

12-23-94

9. AGE (In years
lost birthday)

74

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Ambassador

10B. KIND OF BUSINESS OR INDUSTRY

Peruvian Govt.

11. BIRTHPLACE (State or foreign country)

Peru

12. CITIZEN OF WHAT COUNTRY?

Peru

13. FATHER'S NAME

MANUEL CACHO GALVEZ

14. MOTHER'S MAIDEN NAME

DELIA SOUSA

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL
SECURITY NO.

17. INFORMANT

ADDRESS

JAMES CACHO-SOUSA

18. 4/10/7 I
DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthma, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF

(B) ASCVD
DUE TO, OR AS A CONSEQUENCE OF:

(C) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

YES

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At
Work ☐Not While
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12/16 to 12/16 19 69
that (I) (we) last saw the deceased alive on 12/16 19 69 and that in (my) (our) opinion death occurred on the date
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James E. Muller MD

DEGREE

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/16/69

23C. PHYSICIAN'S
NAME (Type)

JAMES E. MULLER

DEGREE

23D. ADDRESS

1531 E. Monument Blvd

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-19-69

24C. NAME OF CEMETERY or CREMATORY

LaPlanizie Cemetery

24D. LOCATION

(City, town, or county)

Lima, Peru

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 17 1969

25B. NAME OF REGISTRAR

James E. Muller MD

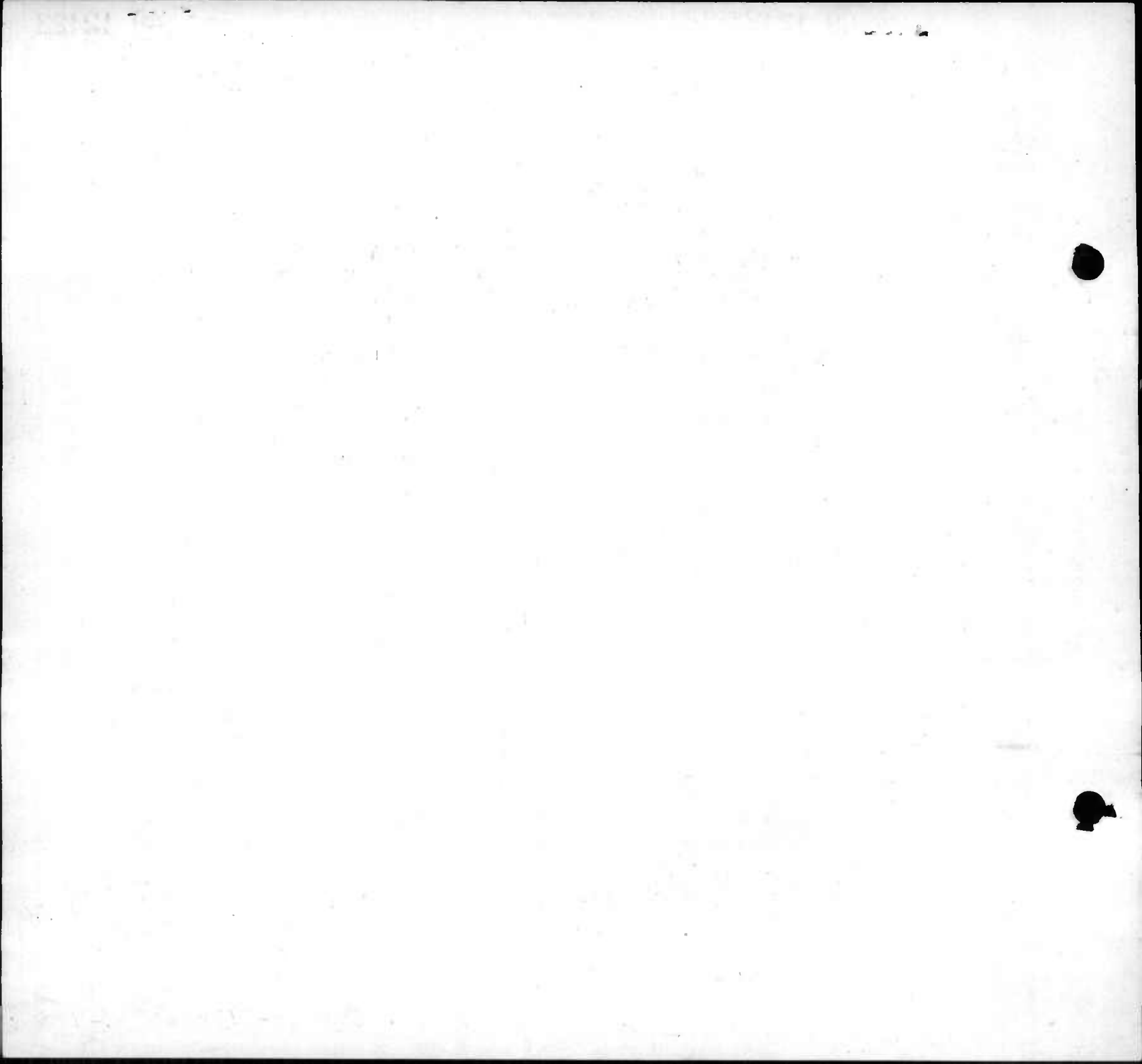
25C. FUNERAL DIRECTOR

John C. Miller Inc-6415 Belair Rd.-21206

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

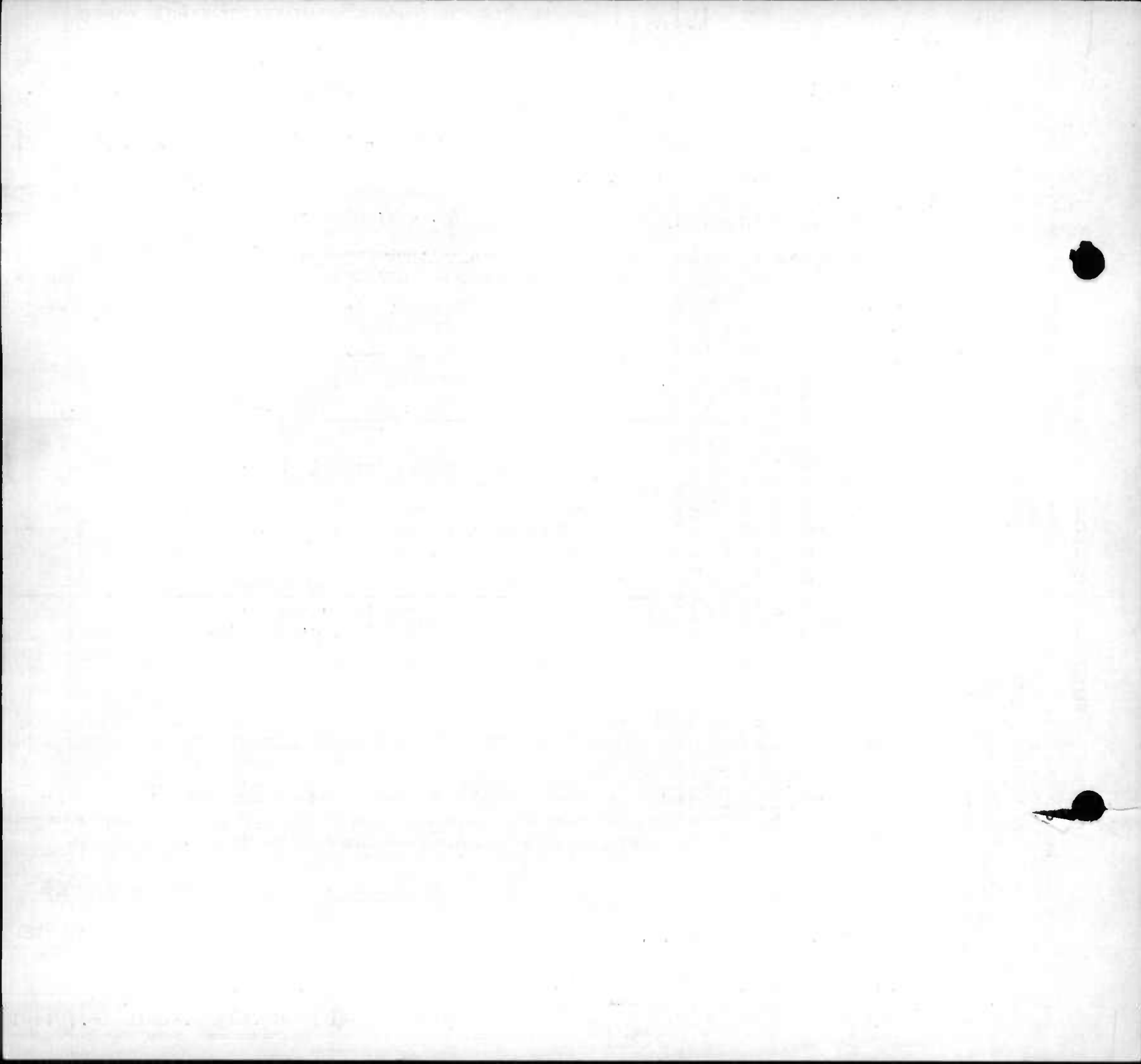
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				69 12424	
M-200		69 12424		69 12424	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Reverend Edward Mackey		2. DATE AND HOUR OF DEATH December 15, 1969 9:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Michigan B. COUNTY Detroit			
FULL NAME OF HOSPITAL OR INSTITUTION The Seton Psychiatric Institute 6400 Wabash Avenue Baltimore, Maryland 21215		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER St. Joseph's Retreat					
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1889	9. AGE (In years lost birthday) 80	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Emmett, Michigan	
12. CITIZEN OF WHAT COUNTRY? United States					
13. FATHER'S NAME John Mackey		14. MOTHER'S MAIDEN NAME Ellen Warren			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT RECORDS: seton Inst.- 6400 Wabash Av., City	
18. 3-60-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Partial intestinal obstruction 5 days		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (c) General and cerebral arteriosclerosis about 5 years		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (c) General and cerebral arteriosclerosis about 5 years			
(b) DUE TO, OR AS A CONSEQUENCE OF: (b) Unknown					
(a) Unknown					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). differentiated type Schizophrenic reaction, chronic in- 42 years					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from November 11, 1961 to December 15, 1969 , that (I) (we) last saw the deceased alive on December 15, 1961 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Walter O. Jahrreiss, M.D.				23B. DATE SIGNED December 16, 1969	
23C. PHYSICIAN'S NAME (Type) Walter O. Jahrreiss, M.D.		23D. ADDRESS 6400 Wabash Avenue, Baltimore, Maryland 21215			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE Dec. 20/69		24C. NAME OF CEMETERY or CREMATORY HOLY SEPULCHRE CEMETERY	
24D. LOCATION Southfield, Michigan					
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR John E. Taylor		25C. FUNERAL DIRECTOR SEWART & MOYEN	
25D. ADDRESS CO. 108 W. North Av., City					



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) S. Donald Hurwitz		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 12/12/ 1969 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 1500 Woodheights Ave.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 12 69 9:38 p.m.	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 2740			
6. SEX male	7. RACE white	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH June 22, 1926		10. AGE (In years last birthday) 43 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late Nathan Hurwitz		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney	
15. MOTHER'S MAIDEN NAME Helen Tucker		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWII Navy	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Mrs. Dorothy Hurwitz- 5908 Key Avenue	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) E 950.0 Barbiturate overdose ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1500 Woodheights Ave. 2765			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 12 12 69 ?		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? ingested overdose of barbiturates			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner 12/13/69 ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Dec 15/69	
24C. NAME OF CEMETERY or CREMATORY Mogan Abraham		24D. LOCATION (City, town, or county) (State) Rosedale, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Sp... Levinson & Bros. Inc.		25D. ADDRESS 6010 Reisterstown Road	

VS177 Dr. Spitz

June 15, 1958

Belmont, Vermont USA

Attorney At Law

Yes 1957-1958

Mr. Kenneth Martin - 5001 New Avenue

John Thayer

John Martin Martin

5001 New Avenue

ACAPILM

100

100

100

100

100

100

100

Resident, Vermont

Dr. Spitz & Son, Inc. 5010

H-620

69 12426 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12426

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <u>Benjamin Charles E. Hirsch</u>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>5466 Lynview Ave.</u>		3. DATE PRONOUNCED DEAD Month Day Year Hour <u>12 12 69 6:25 p.</u> M.	
6. SEX <u>male</u>		7. RACE <u>white</u>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2831</u>	
9. DATE OF BIRTH <u>JULY 12, 1945</u>		10. AGE (In years lost birthday) <u>24</u> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SEYMOUR HIRSCH</u>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>READS DRUG & CHEMICAL CO. PHARMACIST</u>	
15. MOTHER'S MAIDEN NAME <u>DOROTHY GREENBERG</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>	
17. SOCIAL SECURITY NO. <u>220-42-4258</u>		18. INFORMANT ADDRESS <u>SEYMOUR HIRSCH 5509 LYNNVIEW AVE.</u>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <u>2</u>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <u>yes</u>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <u>5466 Lynview Ave. 28-31</u>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>12 ? 69 ? m.</u>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <u>self-administered overdose</u>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>Werner U. Spitz, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner <u>12/13/69</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>DEC. 14/69</u>	
24C. NAME OF CEMETERY or CREMATORY <u>OHNEKNESETH ISRAEL ANKHE SPARD</u>		24D. LOCATION (City, town, or county) (State) <u>ROSEDALE, MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 17 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Carl Hermann & Son, Inc. 6010 Rosters Road</u>		ADDRESS	

Handwritten notes and a circular stamp on the right side of the page.

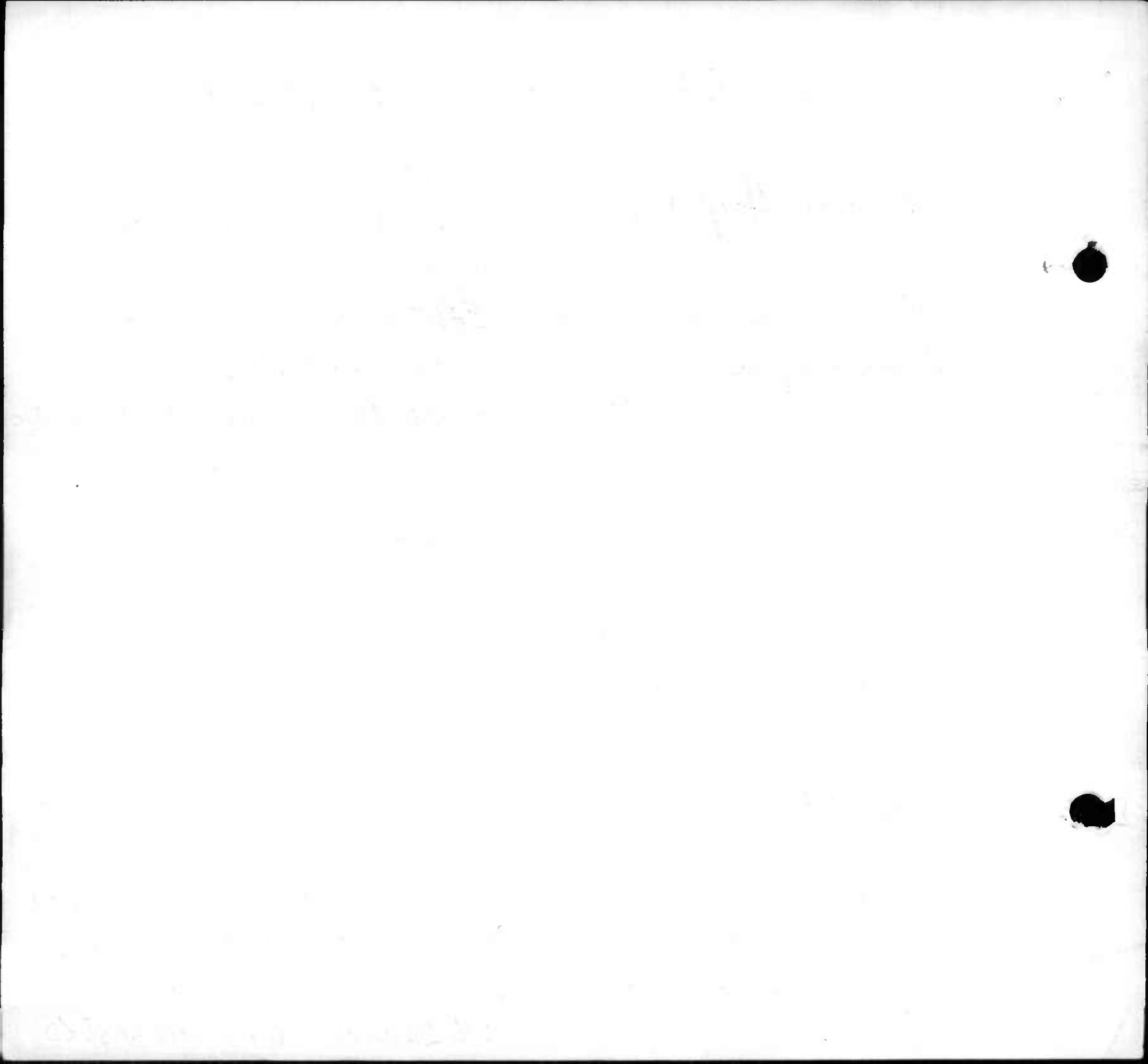
ACADEMY GOLF
VALLEY ESTATE CO

2+

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

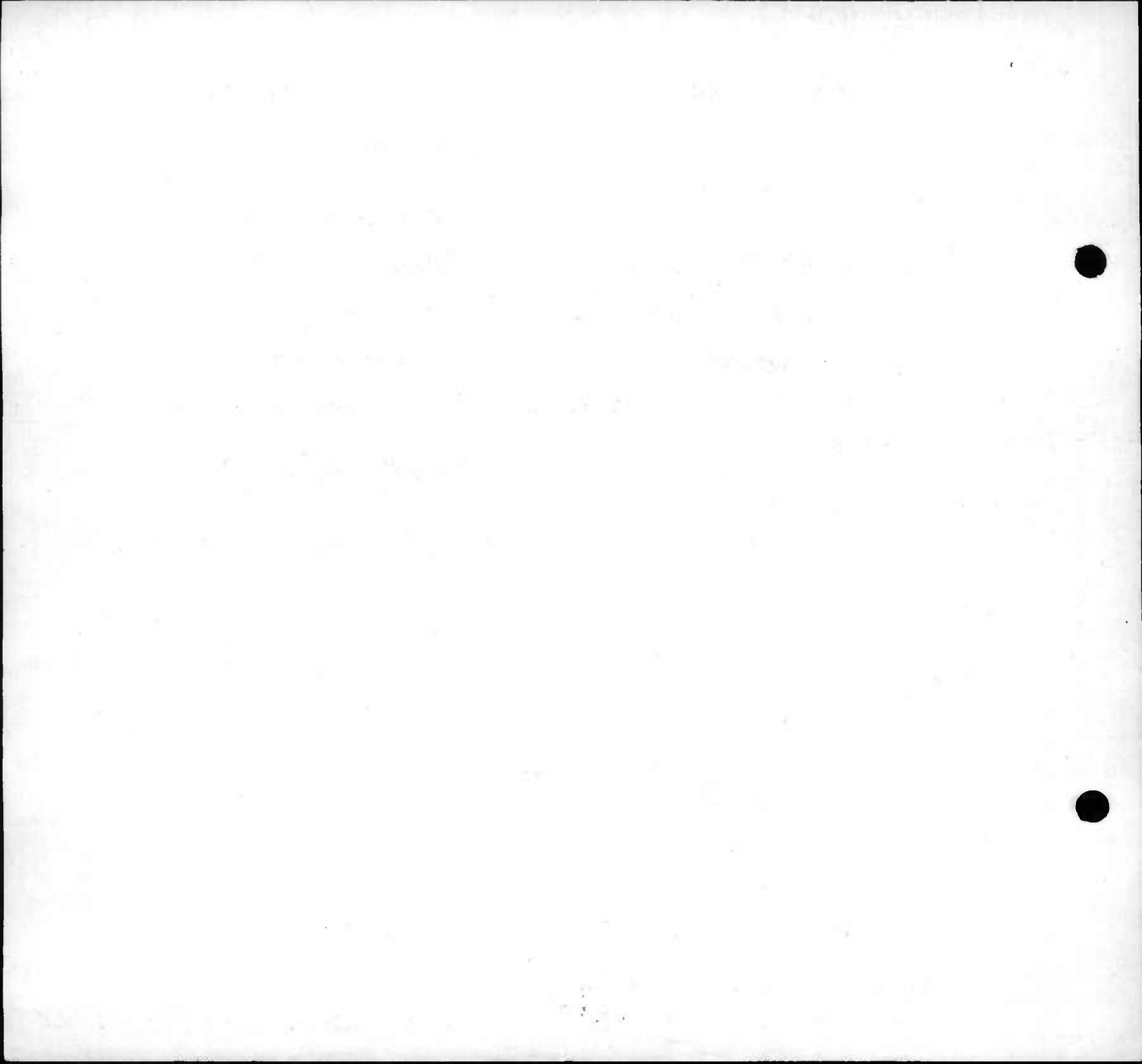
L-200		69 12427		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12427	
CERTIFICATE OF DEATH							
BIRTH NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>MARGARET Lewis</u>				12/12/69 10:35 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>42 Sinai Hospital</u>				C. CITY OR TOWN D. INSIDE CITY LIMITS? <u>BALTIMORE</u> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <u>4009 BOWERS AVE</u>							
5. SEX <u>Female</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 16, 1921</u>	9. AGE (In years last birthday) <u>48</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>MAX SUGAR</u>				14. MOTHER'S MAIDEN NAME <u>MARY BAUMOHL</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>HAROLD Lewis</u>		ADDRESS <u>4009 BOWERS AVE</u>	
18. <u>15291</u> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Generalized peritonitis</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>10 days</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>cancer of the small intestine</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>pneumectomy for cancer</u>							
19A. DATE OF OPERATION <u>Dec. 4, 69</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>poor</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>Dec. 3, 1969</u> to <u>Dec. 12, 1969</u> and that (2) (we) last saw the deceased alive on <u>Dec. 12, 1969</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Koichi Nagamine</u>				23B. DATE SIGNED <u>Dec. 12, 1969</u>			
23C. PHYSICIAN'S NAME (Type) <u>KOICHI NAGAMINE</u>				23D. ADDRESS <u>Sinai Hospital of Baltimore, Inc.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/14/69</u>		24C. NAME of CEMETERY or CREMATORY <u>Tzemech Zeдек</u>		24D. LOCATION (City, town, or county) (State) <u>GERMAN HILL RD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 17 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Fisher, R.D.</u>		25C. FUNERAL DIRECTOR <u>502 LEVINSON & BROS</u>		ADDRESS <u>6000 Reister Rd</u>	



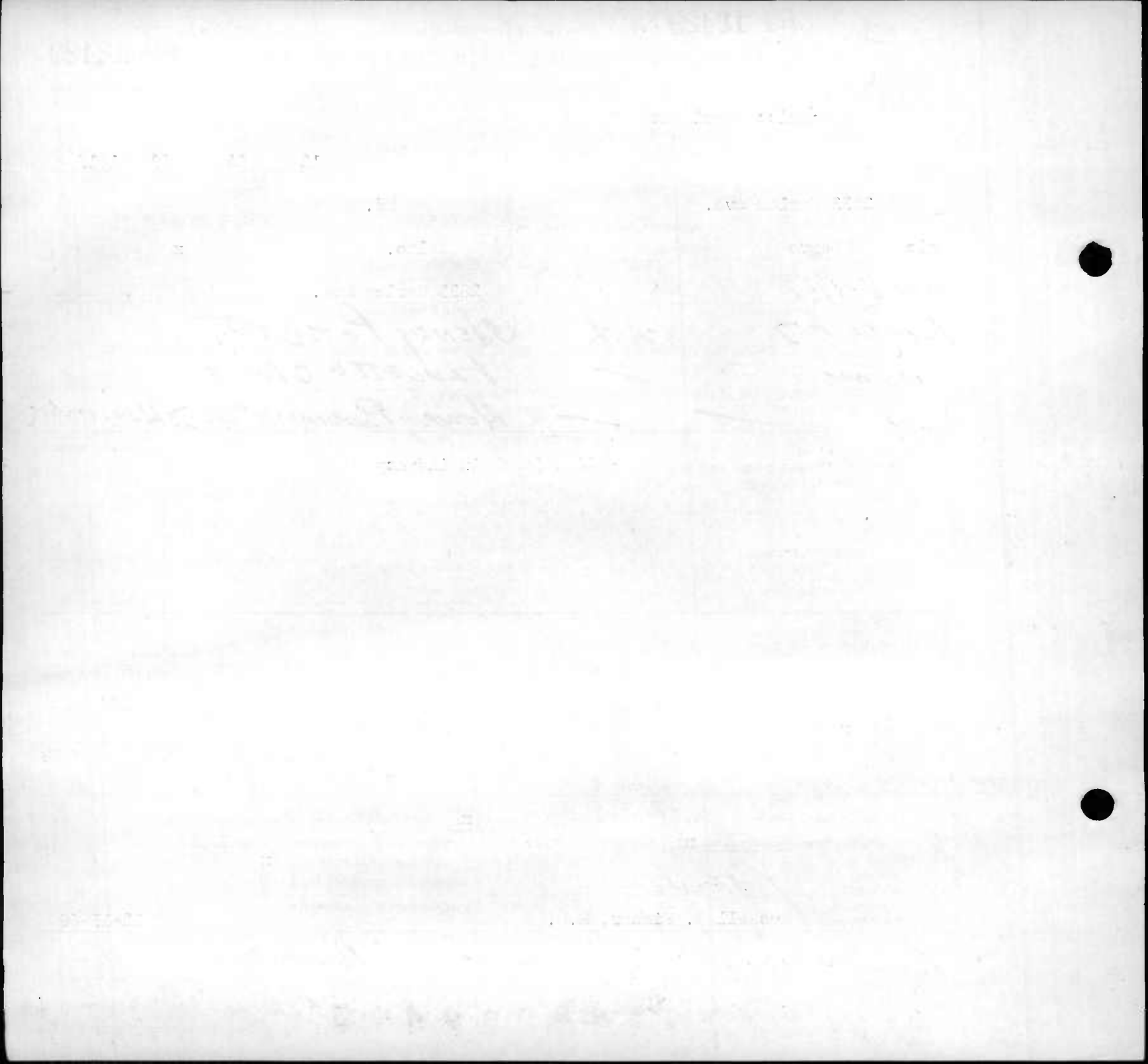
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> B-260 69 12428 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 69 12428 </div>			
1. NAME OF DECEASED (Type or Print) ANNA BOXER		2. DATE AND HOUR OF DEATH DEC 12/13/69 7:30 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Levin Dale Hebrew Home 91 And INFIRMARY		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2740 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3404 GLEN AVE.	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH X-XXXX
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-34-8402	
17. INFORMANT MRS. ROSE LEBIN - 3404 GLEN AVE.		ADDRESS	
18. 4109 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Probable Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min. to	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD		(B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD	
(C) DUE TO, OR AS A CONSEQUENCE OF: Parkinson Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10 27 19 69 to 12 13 19 69 , that (I) (we) last saw the deceased alive on 12 13 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Ellis S. Caplan MD		23B. DATE SIGNED 12/13/69	
23C. PHYSICIAN'S NAME (Type) ELLIS S. CAPLAN		23D. ADDRESS LEVINDALE HEBREW HOME	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC 14/69	
24C. NAME OF CEMETERY or CREMATORY OHEL YAKOV (BETH ISRAEL)		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR John H. ...	
25C. FUNERAL DIRECTOR Sol ...		ADDRESS 6010 Reisterstown Rd.	

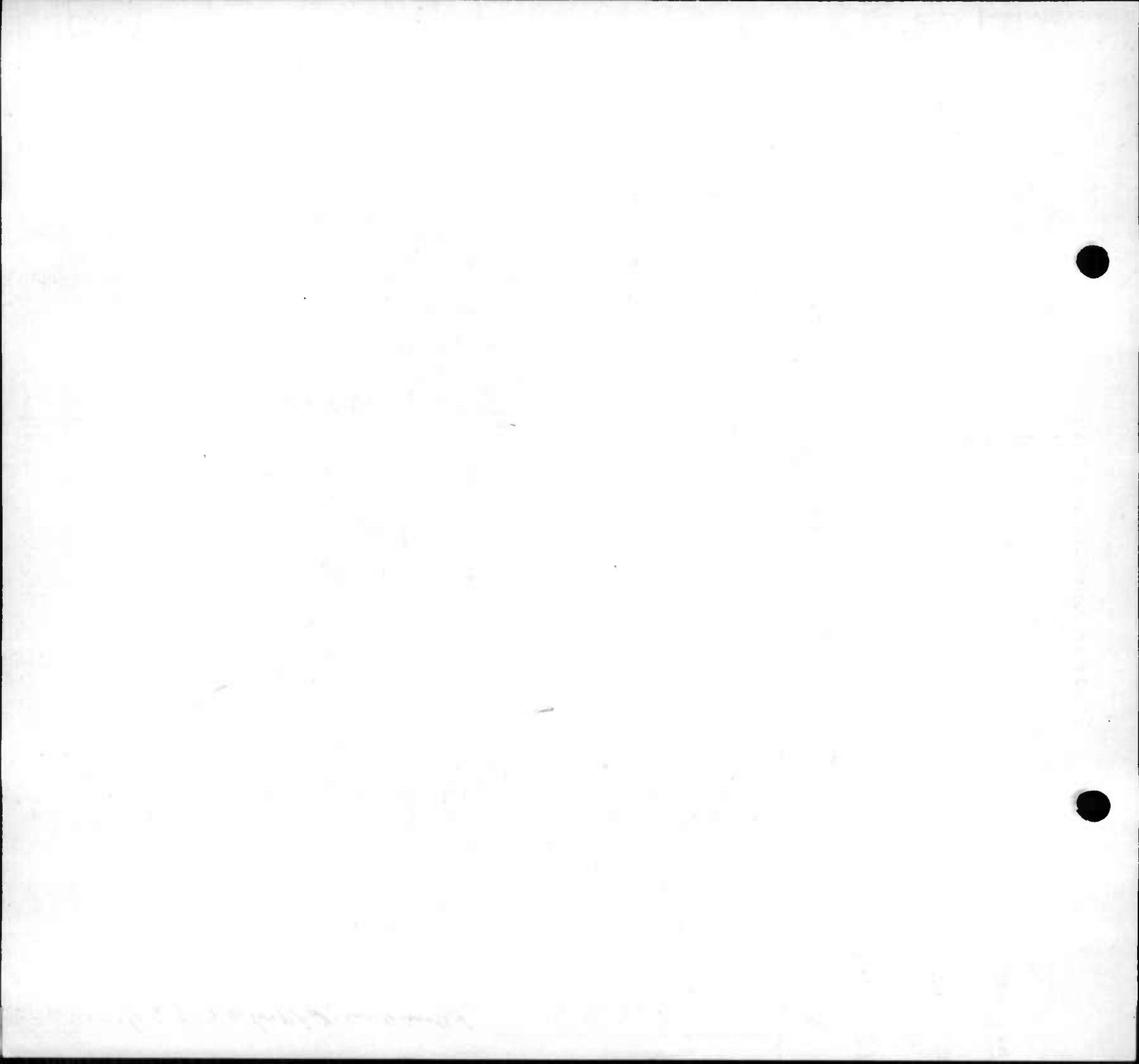


P-623		69 12429		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 69 12429	
BIRTH NO. 69-14491		1. NAME OF DECEASED (Type or Print) Derrick President		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 14 69 11:15 A.M.		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1606	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 2833 Harlem Ave.		6. SEX Male		7. RACE Negro		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH Aug 5-1969		10. AGE (In years last birthday) 4		11. BIRTHPLACE (State or foreign country) BALTO MD		12. CITIZEN OF WHAT COUNTRY? USA		E. STREET AND NUMBER 2833 Harlem Ave.	
13. FATHER'S NAME Henry President		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		15. MOTHER'S MAIDEN NAME PAULETTE CLARK		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO.	
18. INFORMANT Henry President		19. 793X		CAUSE OF DEATH Sudden death in infancy		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		ADDRESS 2833 Harlem Ave	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		24. NAME OF CEMETERY or CREMATORY Mt Auburn		24B. DATE 12-17-69		24C. LOCATION (City, town, or county) (State) Baltimore	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-17-69		24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore		24E. DATE REC'D BY HEALTH DEPT. DEC 17 1969	
24F. NAME OF REGISTRAR Robert E. Fisher, M.D.		24G. NAME OF REGISTRAR Robert E. Fisher, M.D.		24H. FUNERAL DIRECTOR		24I. ADDRESS 638 N. G. Ave. N. Ft.		24J. DATE SIGNED 12-15-69	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250		69 12430		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12430	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) EVA O JACKSON			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				2. DATE AND HOUR OF DEATH 7 10 am 12/16/68			
FULL NAME OF HOSPITAL OR INSTITUTION 46 Lutheran Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2037			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3401 Franklin Street							
5. SEX Female	6. RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-1-82	9. AGE (In years last birthday) 77	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Calvert Co MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Gray				14. MOTHER'S MAIDEN NAME Jennie Murray			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Eva Bridgeford		ADDRESS same as above	
18. 250.9 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE CVA & rt. sided stroke DUE TO, OR AS A CONSEQUENCE OF: (B) + ? Heiney tract infection DUE TO, OR AS A CONSEQUENCE OF: (C) Diabetes mellitus			
19. DATE OF OPERATION 0				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 12/9/69 19 69 to 12/16/69 19 69 , that (I) (we) last saw the deceased alive on 7:10 am 12/16/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Phelicia M. [Signature]				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) Phelicia M. [Signature]	
23D. ADDRESS Lutheran Hospital				23E. FUNERAL DIRECTOR [Signature]			
24A. BURIAL CREMATION, REMOVAL (Specify) Burns		24B. DATE 12/20/69		24C. NAME OF CEMETERY or CREMATORY Wt Auburn		24D. LOCATION (City, town, or county) (State) Baltimore MD	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTERAR [Signature]		25C. FUNERAL DIRECTOR [Signature]			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12431	
BIRTH NO. R-314		69 12431 CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) SARAH RODBELL		2. DATE AND HOUR OF DEATH DECEMBER 14, 1969 2:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 JEWISH CONVELESANT HOME 4601 PALL MALL ROAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2716 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4601 PALL MALL ROAD	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1882 9. AGE (In years last birthday) 87
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) RUSSIA
13. FATHER'S NAME MAYER JANKLOWITZ		14. MOTHER'S MAIDEN NAME LENA ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-24-2352	17. INFORMANT MR. BERNARD JACOBSON, 6800 LIBERTY ROAD #7 BALMORAL APTS, APT. 31
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CHL & coma (B) Microbiotic CN. disease DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
19A. DATE OF OPERATION 6		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from Dec. 20 1958 to Dec. 14 1969 , that (I) (we) lost saw the deceased alive on Dec. 14 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Nathan Needle		23B. DATE SIGNED 12/15/69	23C. PHYSICIAN'S NAME (Type) NATHAN NEEDLE, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-15-69	24C. NAME OF CEMETERY or CREMATORY AITZ CHAIM, WASHINGTON BLVD. MARYLAND
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	25C. FUNERAL DIRECTOR SOL LEVINSON & BROS. 6010 REISTERSTOWN RD.

ALL MAIL ROOM

1961 MAIL ROOM

WHITE

WHITE

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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT
69 12432 CERTIFICATE OF DEATH

REG. NO. 69 12432

B-624

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BRESSLER, Lillian

2. DATE AND HOUR OF DEATH 12-15-69 12 AM

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE MARYLAND B. COUNTY 2730

C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES ☒ NO ☐

E. STREET AND NUMBER 3009 Romaric Ct. #9.

5. SEX Female 6. RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 11-93 9. AGE (In years last birthday) 76 If Under 1 Yr. Months: Days: Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10B. KIND OF BUSINESS OR INDUSTRY at Home 11. BIRTHPLACE (State or foreign country) ENGLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jayar Levy 14. MOTHER'S MAIDEN NAME Sarah?

15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No. 16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Sally Steinberg, 6106 ADDRESS Simlico Rd #9

18. 4-10-71 CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH PULMONARY EDEMA

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES MYOCARDIAL INFARCTION

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, ARTERIOSCLEROTIC VASCULAR DISEASE

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION 0 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) NO 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☐ 21F. HOW DID INJURY OCCUR?

22. I certify that (4) (this hospital) attended the deceased from 12-14-69 19 to 12-15-69 19 that (4) (we) last saw the deceased alive on 12-15-69 19 and that in (4) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.

23A. SIGNATURE M. Bodenheim DEGREE 23B. DATE SIGNED 12-25-69 Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23C. PHYSICIAN'S NAME (Type) M. BODENHEIMER DEGREE 23D. ADDRESS Sinai Hospital of Balto.

24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12-16-69 24C. NAME OF CEMETERY OR CREMATORY Our Kneasseth Israel Anshe Shalom Burman Hill Rd, Md. 24D. LOCATION (City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969 25B. NAME OF REGISTRAR Robert E. Fisher 25C. FUNERAL DIRECTOR Dr. Fisher ADDRESS 6010 Rustic Road

28

(X-2)

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

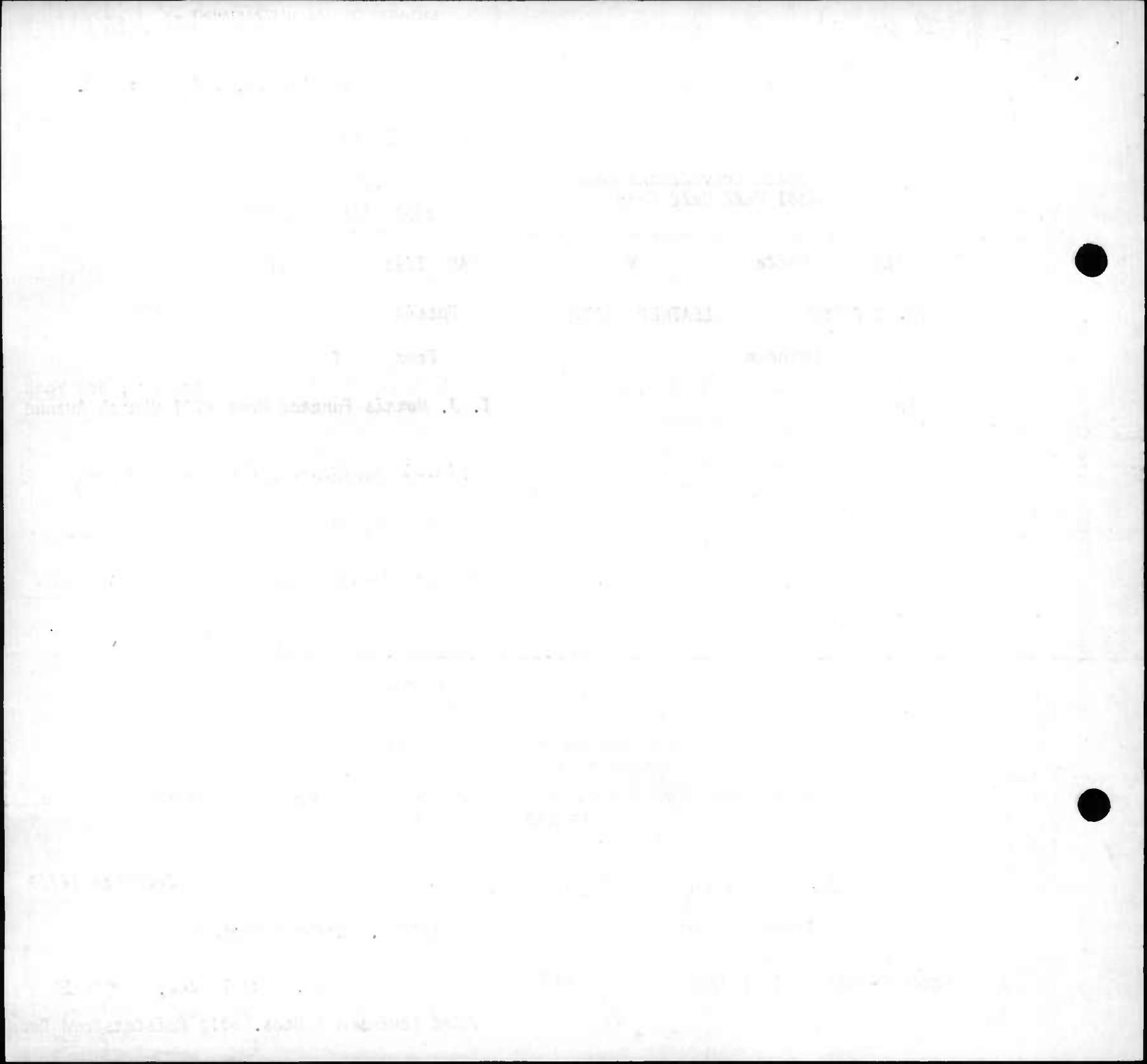
VS 150-REV. 1/1/68

U.S. DEPT. OF AGRICULTURE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

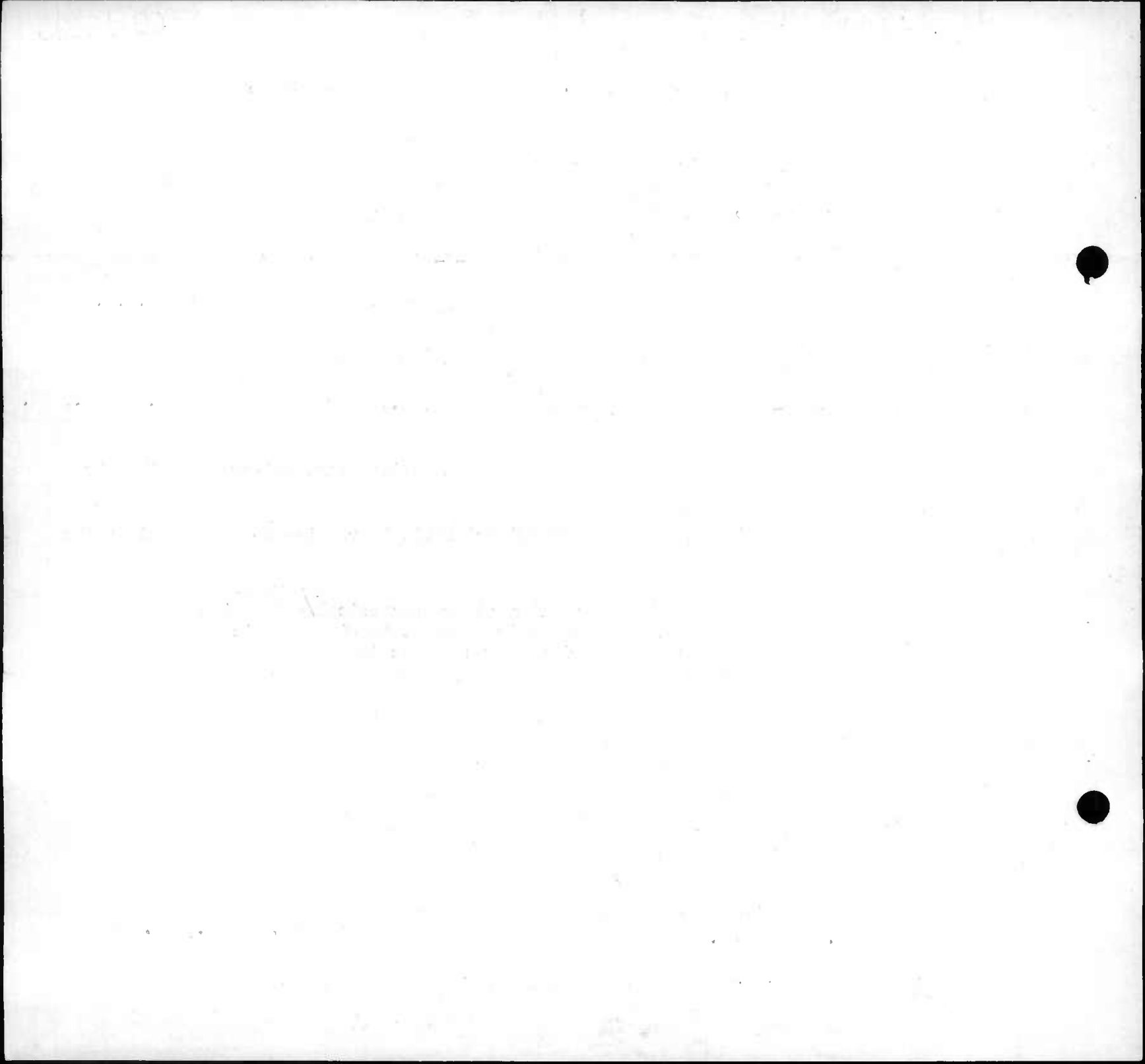
<div style="display: flex; justify-content: space-between;"> G-435 69 12434 BALTIMORE CITY HEALTH DEPARTMENT </div>		<div style="display: flex; justify-content: space-between;"> 69 12434 CERTIFICATE OF DEATH </div>		REG. NO. 69 12434	
BIRTH NO. 1 1. NAME OF DECEASED (Type or Print) JACOB GOLDMAN			2. DATE AND HOUR OF DEATH December 14, 1969 6:45 A. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 90 Jewish Convelesant Home 4601 Pall Mall Road			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 2716 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 4601 PALL MALL ROAD		
5. SEX MALE	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 1882	9. AGE (In years lost birthday) 87	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HAND CHAPPER		10B. KIND OF BUSINESS OR INDUSTRY LEATHER GOODS		11. BIRTHPLACE (State or foreign country) Russia	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Tema ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT I. J. Morris Funeral Home ADDRESS Brooklyn, New York 9701 Church Avenue	
18. 4/12/69 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Ante Cardiac Distention ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. A SHD General Anterior			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) 1 day 10 years 14 years		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 5/1 19 60 to 12/14 19 69 , that (I) (we) last saw the deceased alive on 12/13 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Israel Zinberg DEGREE				23B. DATE SIGNED December 14/69 Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Israel Zinberg		23D. ADDRESS 4000 W. Northern Parkway			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal-Burial		24B. DATE 12/14/1969		24C. NAME OF CEMETERY or CREMATORY Beth David	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. 6010 Reisterstown Road	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12435	
L-220		69 12435		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		LOGIS, JOHN (NMI) SR.		December 14, 1969 8:25 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 2 1218		A. STATE Maryland		B. COUNTY 2505	
		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4123 Morrison Court			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-94	9. AGE (In years last birthday) 75	10. CITIZEN OF WHAT COUNTRY? U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aircraft Worker		10B. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Anthony Logis		14. MOTHER'S MAIDEN NAME Maggie Unknown			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 6-2 4-18 To 7-15-19		16. SOCIAL SECURITY NO. 217-14-0126		17. INFORMANT Records VA, Hosp., 3900 Loch Raven Blvd. Balto., Md.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF: (C) junction Calculus at Ureterovesical/and Benign Prostatic Hypertrophy with Chronic Urinary tract Infection		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Weeks 21 Months	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). II					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from December 8 19 69 to December 14 19 69, that (H) (we) last saw the deceased alive on December 14 19 69 and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.					
23A. SIGNATURE PERRY G. AUSTIN JR. MD				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME PERRY G. AUSTIN JR. MD				23D. ADDRESS 3900 Loch Raven Blvd. Balto., Md. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12-18-69		24C. NAME OF CEMETERY OR CREMATORY London Park Cemetery	
24D. LOCATION (City, town, or county) (State) Balto. 21229. Md		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Taylor, R.D.	
25C. FUNERAL DIRECTOR John W. Nahn		25D. ADDRESS 4200 Pennington Ave			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-300		69 12436		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12436	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
SCOTT, MARY C.				December 14 1969 9.30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
44 UNION MEMORIAL Hospital				MARYLAND 1307			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				3711 BEECH AVENUE			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	02-18-85	84			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		-		Ireland Scotland		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JAMES EDGAR				ELLEN SMITH			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		-		Alfreda M Scott		Same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Bronchopneumonia			
ANTECEDENT CAUSES				DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Chronic Obstructive Lung Disease			
				DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December 11 19 69 to December 14 19 69 that (I) (we) last saw the deceased alive on December 14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Miguel Karacuschansky M.D.				December 14, 1969			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Miguel KARACUSCHANSKY MD.				UNION MEMORIAL Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		17 Dec 69		Druid Ridge		Pikesville Balt Co Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
DEC 17 1969		J. E. Fisher, M.D.		Burger Funeral Home		13216 Md	

Union Memorial Hospital

3511 BROWN STREET

WHITE

X

03-18-82

24

THOMAS

ELLEN SMITH

JAMES EDGAR

Grandchildren

Chronic Obstructive Lung Disease

BC

December 19 82

Union Memorial Hospital

Medical Records

James Edgar

December 19 82

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-420		69 12437		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12437	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) ALLIE WELLS				2. DATE AND HOUR OF DEATH 12/15/69 6:11 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MD B. COUNTY DALTIMORE C. CITY OR TOWN 2739 D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5300 LEITH RD			
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/29/91		9. AGE (In years last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Silas Whitby				14. MOTHER'S MAIDEN NAME MARY E			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 224 01 1881		17. INFORMANT Mrs LAURIE JARVIS		ADDRESS same	
18. 410.91 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). CONGESTIVE HEART Failure				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCTION		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hrs.	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from DEC. 14 19 69 to DEC 15 19 69 that (1) (we) lost saw the deceased alive on DEC 15 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Victor Borden M.D.				23B. DATE SIGNED 12/15/69		23C. PHYSICIAN'S NAME (Type) VICTOR BORDEN M.D.	
23D. ADDRESS SINAI HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Buried		24B. DATE 12-17-69		24C. NAME of CEMETERY or CREMATORY Blandford Cern		24D. LOCATION (City, town, or county) (State) Petersburg, VA	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Jones, Jr.		25C. FUNERAL DIRECTOR Burges Funeral Home		ADDRESS Bs 16 Md	

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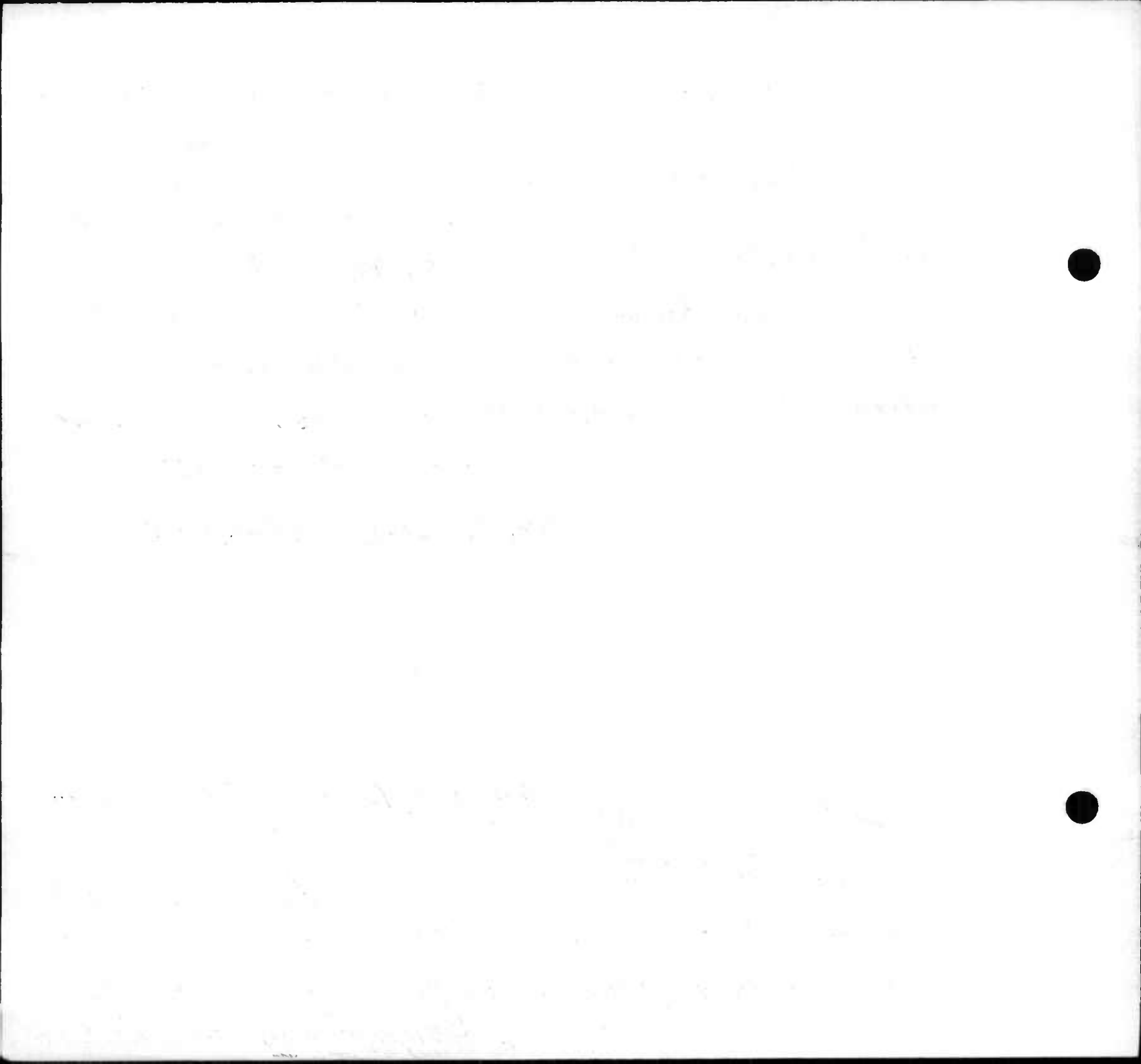
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> R-400 69 12438 BALTIMORE CITY HEALTH DEPARTMENT </div> <div style="display: flex; justify-content: space-between;"> CERTIFICATE OF DEATH REG. NO. 69 12438 </div>			
BIRTH NO. 1 1. NAME OF DECEASED (Type or Print) REILLY, THEODORE S.		2. DATE AND HOUR OF DEATH 12/14 1969 10 20 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL 44		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY Baltimore C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1146 ROLAND HEIGHTS AVE	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/30/1908
9. AGE (In years last birthday) 61		10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer (R.R.) 10B. KIND OF BUSINESS OR INDUSTRY Steel Mfg. Plant	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THEODORE S. REILLY SR.		14. MOTHER'S MAIDEN NAME JULIA RYAN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 3C8S/4132705124021	17. INFORMANT Thelma M. Reilly ADDRESS same
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CARDIAC ARREST ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. MYOCARDIAL INFARCTION		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that it (this hospital) attended the deceased from 7:15 PM 12/14 1969 to 10:20 PM 12/14 1969 that (I) we last saw the deceased alive on 10 PM 12/14 1969 and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) We (did) (did not) view the body after death.			
23A. SIGNATURE Doctor Paul Mikus		23B. DATE SIGNED 12/14/69	
23C. PHYSICIAN'S NAME (Type) J. PAUL MIKUS, M.D.		23D. ADDRESS UNION MEMORIAL HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 18 Dec 69	
24C. NAME of CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Overlee Bldg 6 Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Talley, R.D.	
25C. FUNERAL DIRECTOR Burger Funeral Home		ADDRESS Baltimore	



Y-535 69 12439

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12439

BIRTH NO.

1. NAME OF DECEASED (Type or Print) E. Elizabeth Von Den Bosch		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) South Baltimore General (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 14 69 9:05 P.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2505	
9. DATE OF BIRTH Nov 27, 1911		10. AGE (In years last birthday) 58 34 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress		14B. KIND OF BUSINESS OR INDUSTRY Restaurant	
15. MOTHER'S MAIDEN NAME Mamie Conners		13. FATHER'S NAME George F. Gutermuth	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 220-01-5726	
18. INFORMANT Mr. Charles Von Den Bosch		ADDRESS 21225 1010 Bristol Pl	
19. E950.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Overdose of barbiturates (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1010 Bristol Pl. 2505			
22D. TIME OF INJURY (APPROX.) 12-14-69 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Ingested overdose of barbiturates at home.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. DATE SIGNED 12-15-69 EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/69	
24C. NAME OF CEMETERY or CREMATORY Schwartz's Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR M. Kelly F.H.		ADDRESS 237 Patapsco Ave. 21225	

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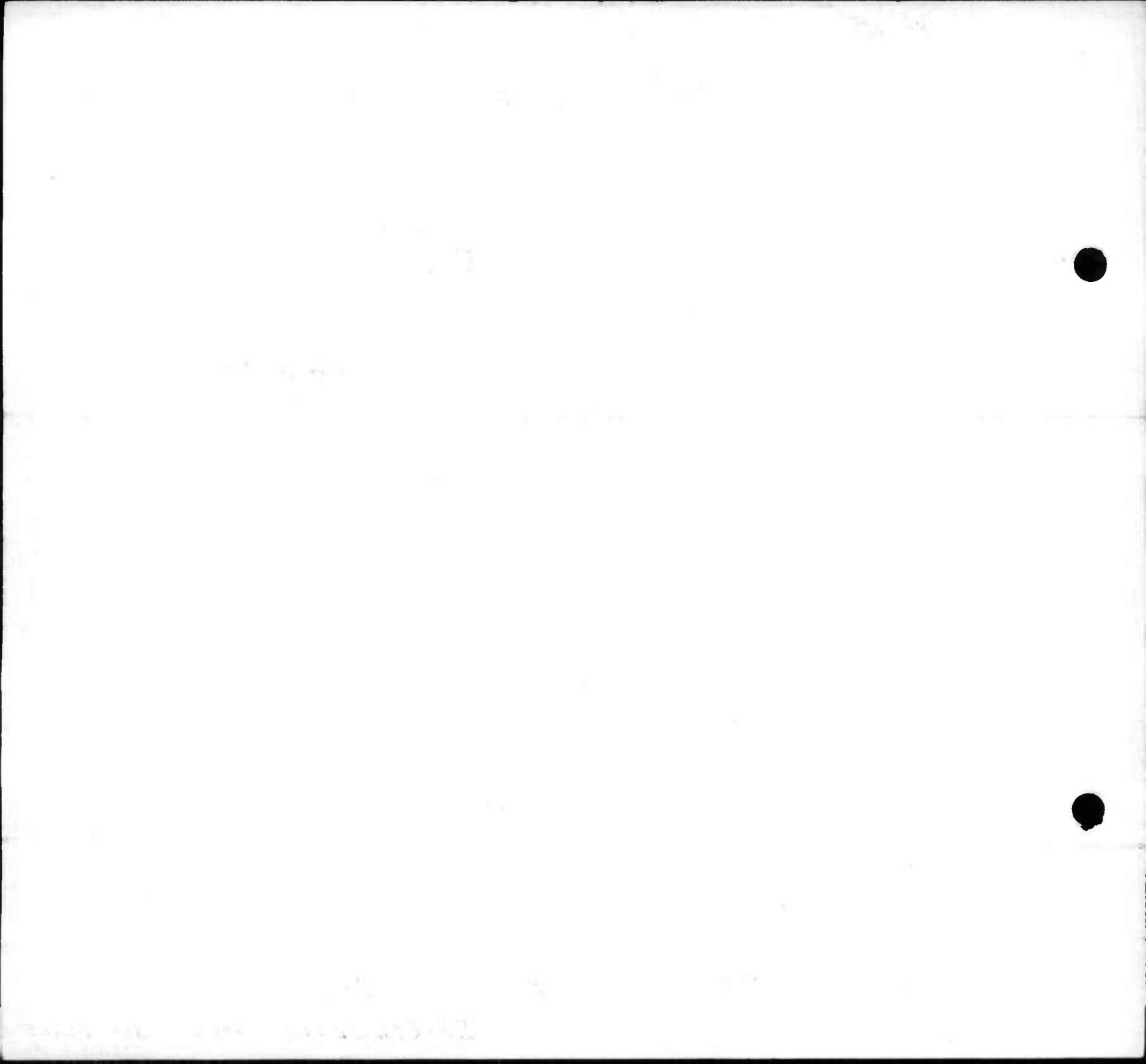
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This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

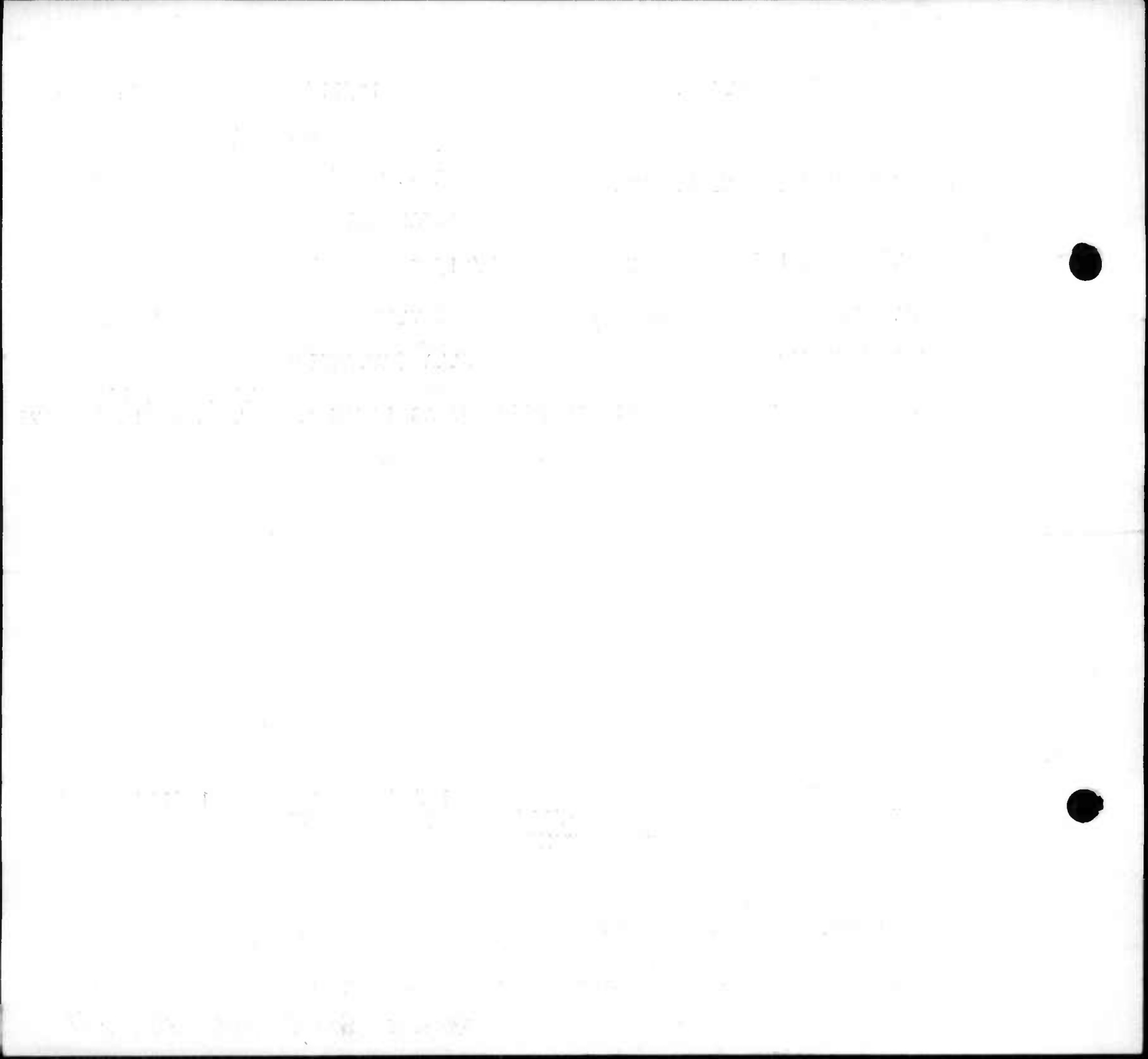
M-450		69 12440		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		69 12440			
BIRTH NO.						2							
1. NAME OF DECEASED (Type or Print) <u>MULLEN, WILLIAM E</u>						2. DATE AND HOUR OF DEATH <u>12/12/69</u> <u>1 8:21 P</u> M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>University of Maryland Hospital</u>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Balt Md</u> B. COUNTY <u>5300</u>							
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Maryland Hospital</u>						C. CITY OR TOWN <u>Balt Md</u>			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
5. SEX <u>Male</u> 6. RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>5/3/03</u>			9. AGE (In years last birthday) <u>66</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Analyst</u>						10B. KIND OF BUSINESS OR INDUSTRY <u>Martin Co.</u>			11. BIRTHPLACE (State or foreign country) <u>Md</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Mullen</u>						14. MOTHER'S MAIDEN NAME <u>Hellie Clark Mullen</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>215-09-2427</u>			17. INFORMANT <u>Patricia Dwyer</u>			ADDRESS <u>Same</u>	
18. CAUSE OF DEATH I <u>250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ASEVD; -Mural</u>						(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Sepsis; Cardiovascular Shock</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>				
						(B) <u>Sepsis 2 to wound abscess</u> DUE TO, OR AS A CONSEQUENCE OF:							
						(C) <u>Dissected Pellets</u>							
MEDICAL CERTIFICATION													
19A. DATE OF OPERATION <u>12/9/69</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Posterior Endarterectomy</u>			20A. AUTOPSY? (Yes or No) <u>Yes</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>11/24/69</u> to <u>12/1/69</u> that (I) (we) last saw the deceased alive on <u>12/1/69</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.													
23A. SIGNATURE <u>Harold J. Kaplan MD</u>						23B. DATE SIGNED <u>12/12/69</u>							
23C. PHYSICIAN'S NAME (Type) <u>HAROLD J KAPLAN MD</u>						23D. ADDRESS <u>U. of Md Hosp Balt Md</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>12/16/69</u>			24C. NAME OF CEMETERY OR CREMATORY <u>LODGE PARK</u>			24D. LOCATION <u>BALTO. MD</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 17 1969</u>						25B. NAME OF REGISTRAR <u>Robert E. Farber MD</u>			25C. FUNERAL DIRECTOR <u>DEKORRELLY SONS</u>			ADDRESS <u>300 MALE</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-600		BALTIMORE CITY HEALTH DEPARTMENT		X	
69 12441		CERTIFICATE OF DEATH		REG. NO. 69 12441	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) HOYER, KENLY T.		2. DATE AND HOUR OF DEATH 12/11/69 11:10 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY Carroll 56-00			
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSP., BALTO., MD. 40		C. CITY OR TOWN BALTO. Woodbine		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER MORGAN ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/85	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10B. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U S A		13. FATHER'S NAME JOSEPH HOYER		14. MOTHER'S MAIDEN NAME ELLA (WALTMYER)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212 22 9668		17. INFORMANT BALTO. MD. 21228 ST AGNES HOSP., BALTO. & WILKENS AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH PNEUMONIA WITH SEPTICEMIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RUPTURED GALL BLADDER (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4-5 days 4-5 days	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 12. 11. 69. 11:10		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from 12/6/69 to 12/11/69 that (X) (we) last saw the deceased alive on 12/11/69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.			
23A. SIGNATURE Raban Ayagan MD		23B. DATE SIGNED 12/12/69		23C. PHYSICIAN'S NAME (Type) Raban Ayagan MD	
23D. ADDRESS St. Agnes Hospital Balto Md		24A. BURIAL CREMATION, REMOVAL (Specify) Burial			
24B. DATE 12-15-69		24C. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial Park		24D. LOCATION (City, town, or county) (State) Elkridge Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Henry W. Knight Lykensville, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> R-525 69 12442 BALTIMORE CITY HEALTH DEPARTMENT </div>		CERTIFICATE OF DEATH		REG. NO. 69 12442	
BIRTH NO. 8-525		1. NAME OF DECEASED (Type or Print) RANZENBERGER Louis		2. DATE AND HOUR OF DEATH 12/12/1969 6:30 PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHASE		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY MD		5. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. STREET AND NUMBER 10 N. Broadway		7. AGE (In years last birthday) 77		8. DATE OF BIRTH 10/20/1922	
9. SEX M 10. RACE W 11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Louis RANZENBERGER	
14. MOTHER'S MAIDEN NAME Susan Walther		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) yes (If yes, give war or dates of service) WWI		16. SOCIAL SECURITY NO. 207030859	
17. INFORMANT Ms. Emma Ranzenberger ADDRESS 3518 Esther Place		18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH Keep Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebral Vascular Accident (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 12/3/69 19 to 12/12/69 19 that (I) (we) last saw the deceased alive on 12/12/69 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE [Signature]		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) F. [Signature]	
23D. ADDRESS [Signature]		24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 12/15/69 24C. NAME OF CEMETERY OR CREMATORY Holly Hill Memorial Gardens Baltimore, Maryland			
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969 25B. NAME OF REGISTRAR Robert E. [Signature] 25C. FUNERAL DIRECTOR John A. Moran, Inc. ADDRESS 3000 E. Baltimore St			

address is 3518 E. 8th St. P.O.

W-252

69 12443

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12443

BIRTH NO.

REG. NO.

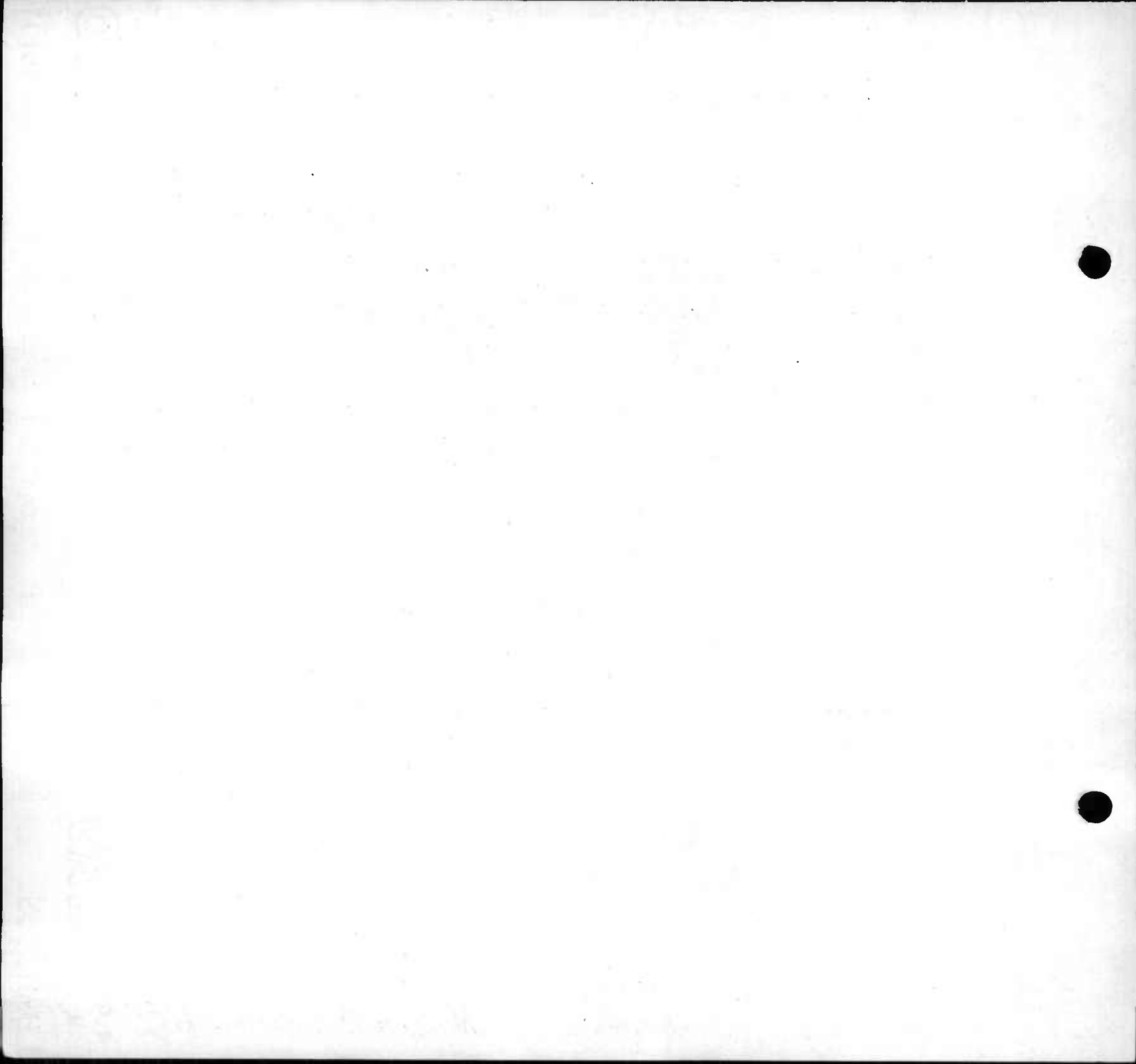
1. NAME OF DECEASED (Type or Print) John Wisniewski		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 527 S. Caroline St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 13 69 8:20 a. M.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH ?		10. AGE (In years last birthday) 65	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME UNKNOWN		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 203	
15. MOTHER'S MAIDEN NAME UNKNOWN		E. STREET AND NUMBER 527 S. Caroline St.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT WALTER WISNIEWSKI		ADDRESS 6622 HARTWAT	
19. CAUSE OF DEATH I 571.8 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Fatty alteration of liver (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (b) DUE TO, OR AS A CONSEQUENCE OF: (c) DUE TO, OR AS A CONSEQUENCE OF: II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21. AUTOPSY? (Yes or No) yes	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M. D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12/13/69			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/16/69	
24C. NAME OF CEMETERY or CREMATORY Holy ROSARY Cem.		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Raymond H. KACZOROWSKI		ADDRESS 2525 FLEET ST.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

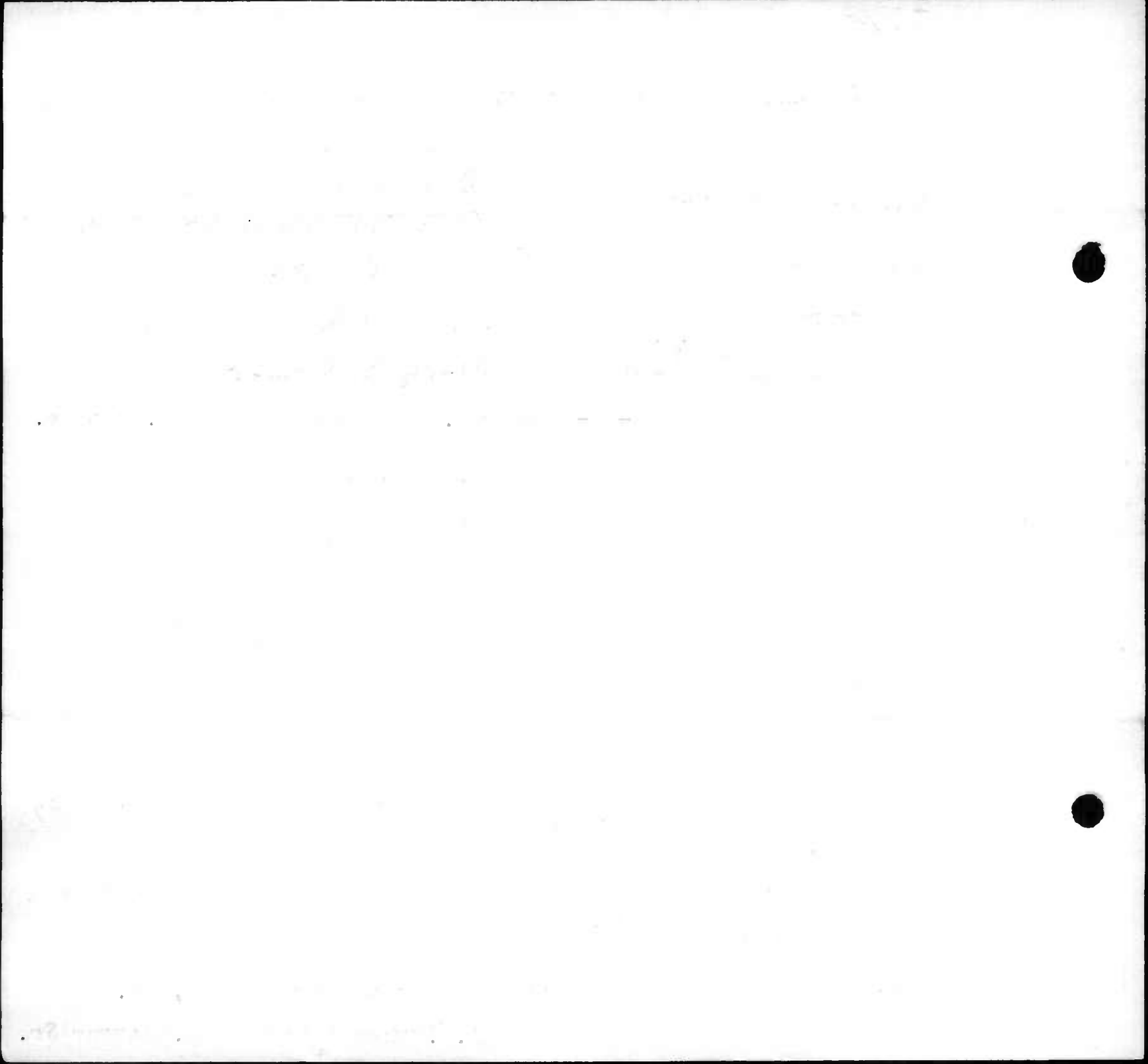
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12444	
L-120 69 12444		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CASIMIR LIPKA		2. DATE AND HOUR OF DEATH DEC. 10 69 730 P.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 JOHNS HOPKINS HOSP.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 427 N. BELNORD AVE.	
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 25 1898
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SELF EMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY TAVERN RET.	
13. FATHER'S NAME JOHN LIPKA		14. MOTHER'S MAIDEN NAME ANNA LACKIEWICZ	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or doles of service) YES		16. SOCIAL SECURITY NO. 213-07-2880	
18. 39579 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ant any ocacardial insufficiency corotic stenosis		17. INFORMANT MR. PHILLIP LIPKA ADDRESS SAME	
19. DATE OF OPERATION 2		20A. AUTOPSY? (Yes or No) yes	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from Jan 6 1969 to Jan 10 1969 , that (I) (we) last saw the deceased alive on Nov. 21 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (they) (did not) view the body after death.	
23A. SIGNATURE L.C. Dobihal		23B. DATE SIGNED 12/12/69	
23C. PHYSICIAN'S NAME (Type) L.C. Dobihal, M.D.		23D. ADDRESS 447 N. KENNEDY AVE. BALTO, MD. 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE DEC. 15, 1969	
24C. NAME OF CEMETERY OR CREMATORY ST. STANISLAUS CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE M.D.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR RAYMOND E. KACZOROWSKI	
25C. FUNERAL DIRECTOR RAYMOND E. KACZOROWSKI		25D. ADDRESS 2525 FLEET ST	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-450		69 12445		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12445	
1. NAME OF DECEASED (Type or Print) <u>XXXXXXXXXXXXXXXXXXXX JAMES SOLEN</u>				2. DATE AND HOUR OF DEATH <u>12-13-69</u> <u>5 30</u> <u>PM</u>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mercy Hospital</u>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1205</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1713 St. Paul St. # 2</u>					
5. SEX <u>M</u>		6. RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-6-85</u>		9. AGE (in years last birthday) <u>84</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>SHEETMETAL</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Thomas D. SOLEN</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Comer</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>457-07-2001</u>		17. INFORMANT <u>MISS ANNE BURROWS</u> ADDRESS <u>1713 ST. PAUL ST.</u>			
18. <u>410.9</u> I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Chronic obstructive lung disease</u>									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>-</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>-</u>					
21D. TIME OF INJURY (APPROX.) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>					
22. I certify that (I) (this hospital) attended the deceased from <u>12-10-69</u> 19 to <u>12-13-1969</u> that (I) (we) last saw the deceased alive on <u>12-13-69</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>AH Ghiladi</u>				23B. DATE SIGNED <u>12-15-69</u>		23C. PHYSICIAN'S NAME (Type) <u>Abdelhamed Ghiladi</u>			
23D. ADDRESS <u>Mercy Hosp. Balto Md. 21202</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>12/15/69</u>		24C. NAME of CEMETERY or CREMATORY <u>DULANEY VALLEY MEMORIAL</u>		24D. LOCATION (City, town, or county) (State) <u>COCKEYSVILLE, MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 17 1969</u>		25B. NAME OF REGISTRAR <u>John E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>H.W. MEARS & SON 805 N. CALVERT ST.</u>					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-600		69 12446		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12446	
BIRTH NO.							
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) MARGARET M. SCHORR				2. DATE AND HOUR OF DEATH 12/13/69 12:30 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL HOSPITAL				A. STATE MD. B. COUNTY 2609			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
				D. STREET ADDRESS (If rural, give location) 3908 FAIR AVE. #21224			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6/15/20	9. AGE (In years last birthday) 49	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BERNARD P. RAAB				14. MOTHER'S MAIDEN NAME MARY MACK			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-01-0413		17. INFORMANT JOHN G. SCHORR		ADDRESS SAME.	
18. 154.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of rectum DUE TO (B) metastatic to brain + bone. DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 1964							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CA - rectum		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/18 19 69 to 12/13 19 69 , that (I) (we) last saw the deceased alive on 12/13 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE M. F. Whitworth				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/13/69	
23C. PHYSICIAN'S NAME (Type) MICHAEL F. WHITWORTH				23D. ADDRESS MD. GEN. HOSP			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-16-69		24C. NAME OF CEMETERY or CREMATORY SACRED HEART CEM.		24D. LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD. BA.CO., MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR John C. Fisher, MD		25C. FUNERAL DIRECTOR John J. Fecker		25D. ADDRESS 900 Conkling St. S. BALTIMORE, MD.	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12447	
BIRTH NO. 69 12447				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Clarice Lee Bennett			2. DATE AND HOUR OF DEATH 15 Dec 1969 0710A M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Union Memorial Hospital			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md B. COUNTY 2748		
			C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5608 Woodmont Avenue		
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 09-13-98		9. AGE (In years last birthday) 71
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LIBRARIAN		10B. KIND OF BUSINESS OR INDUSTRY LIBRARY	11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME KENNETH M. CRAIG			14. MOTHER'S MAIDEN NAME ELIZABETH E. HEADERWICK		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-40-5774	17. INFORMANT Hospital Chart		
18. 483X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) BRONCHOPNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: BRONCHOPNEUMONIA		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH D.H.
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 12-18-69		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-08-1969 to 12-15-1969 that (I) (we) last saw the deceased alive on 12-15-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. Cepeda M.D.			23B. DATE SIGNED 15 Dec 69		23C. PHYSICIAN'S NAME (Type) M. CEPEDA
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			24B. DATE 12-18-69		24C. NAME OF CEMETERY OR CREMATORY OXFORD CEMETERY
24D. LOCATION OXFORD			24E. ADDRESS Union Memorial Hospital		24F. (City, town, or county) (State) Talbot Co Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Blair E. Talbot, M.D.		25C. FUNERAL DIRECTOR Wm. Cook Brooks Towson Inc.	
				ADDRESS 1030 YORK Rd. Towson, Md.	

The date of the ...

The date of the ...

10-13-18

10-13-18

from ...

from ...

Hospital ...

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10-13-18

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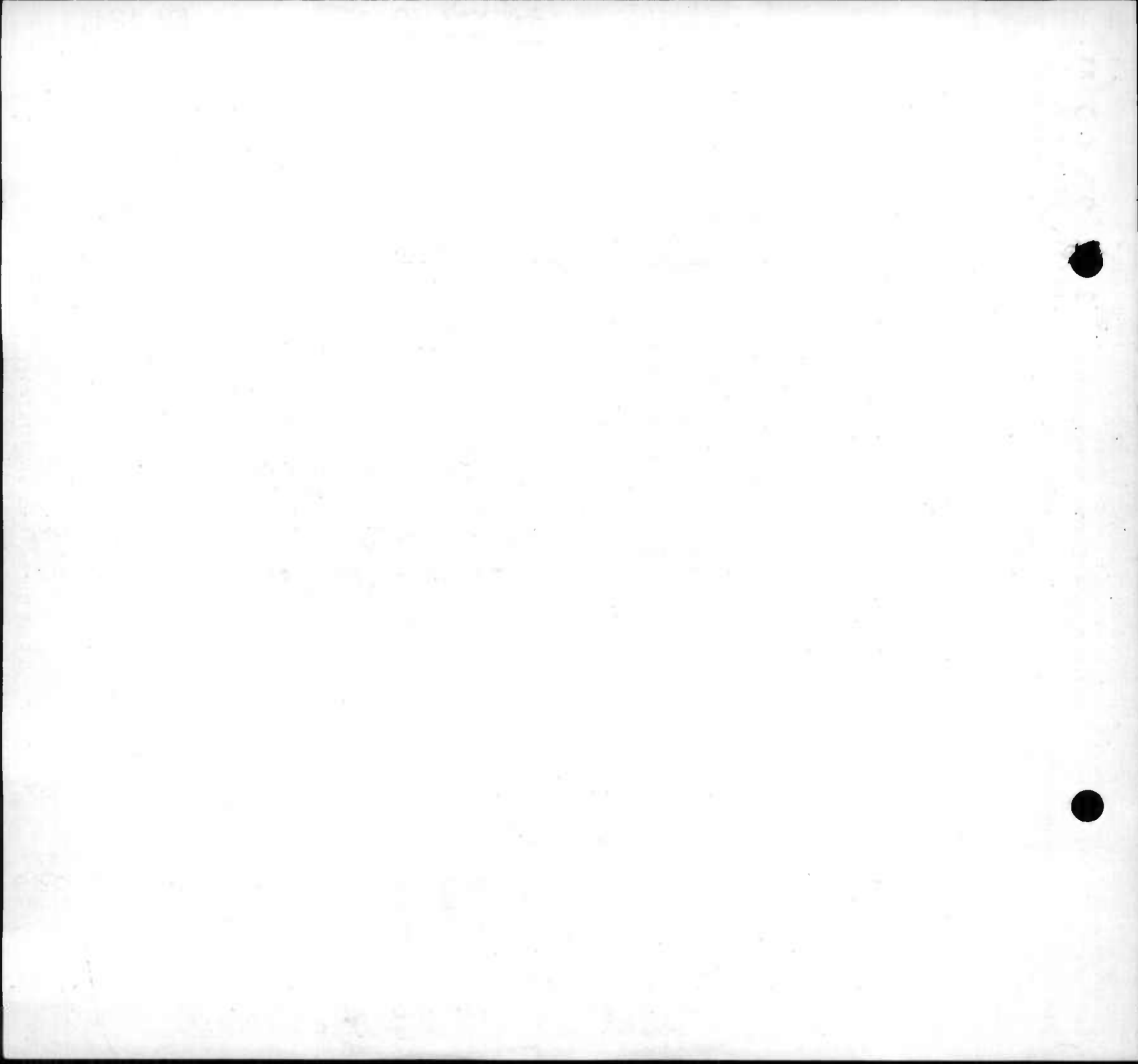
10-13-18

from ...

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-630 69 12448		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12448	
BIRTH NO. 69-23371					
1. NAME OF DECEASED (Type or Print) Baby Boy of Brenda Britt		2. DATE AND HOUR OF DEATH 12/15/69		3:45 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Baltimore Maryland B. COUNTY 907			
FULL NAME OF HOSPITAL OR INSTITUTION 33 The Johns Hopkins Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 1502 Abbottston Street		21218	
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/08/69	9. AGE (In years lost birthday) 7	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Brenda Britt			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 03591 CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIORESPIRATORY ARREST (B) PREMATURITY, UREMIA (C) SEPTISEMIA, APNEC SPELLS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min LIFETIME LIFETIME	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DEC 8 1969 to DEC 15 1969, that (I) (we) last saw the deceased alive on DEC 15 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE G R Greene MD				23B. DATE SIGNED DEC 15, 1969	
23C. PHYSICIAN'S NAME (Type) Gerald R. Greene, M.D.		23D. ADDRESS The Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12/16/69		24C. NAME OF CEMETERY or CREMATORY Johns Hopkins Hospital	
24D. LOCATION 601 N. Broadway		Balto., Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Fisher, MD		25C. FUNERAL DIRECTOR ADDRESS HOSPITAL DISPOSAL	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12449	
BIRTH NO. 5-650				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Baby Scram		2. DATE AND HOUR OF DEATH 12/16/69 @ 3:22 AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1205			
FULL NAME OF HOSPITAL OR INSTITUTION Johns Hopkins Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1601 St Paul Street					
5. SEX Male	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/69	9. AGE (In years last birthday) 12	10. Under 1 Yr. Months Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Willard Scram		14. MOTHER'S MAIDEN NAME Bernice King		12. CITIZEN OF WHAT COUNTRY? America	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: PREMATURITY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 MIN	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from DEC 16 1969 to DEC 16 1969 that (1) (we) last saw the deceased alive on DEC 16 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Gerald R. Greene, M.D.		23B. DATE SIGNED DEC 16, '69		23C. PHYSICIAN'S NAME (Type) Gerald R. Greene, M.D.	
23D. ADDRESS The Johns Hopkins Hospital					
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 12/16/69		24C. NAME OF CEMETERY or CREMATORY Johns Hopkins Hospital	
24D. LOCATION 601 N Broadway		24E. (City, town, or county) Balto., Md.		24F. (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Talley, Jr.		25C. FUNERAL DIRECTOR ADDRESS	
HOSPITAL DISPOSAL					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

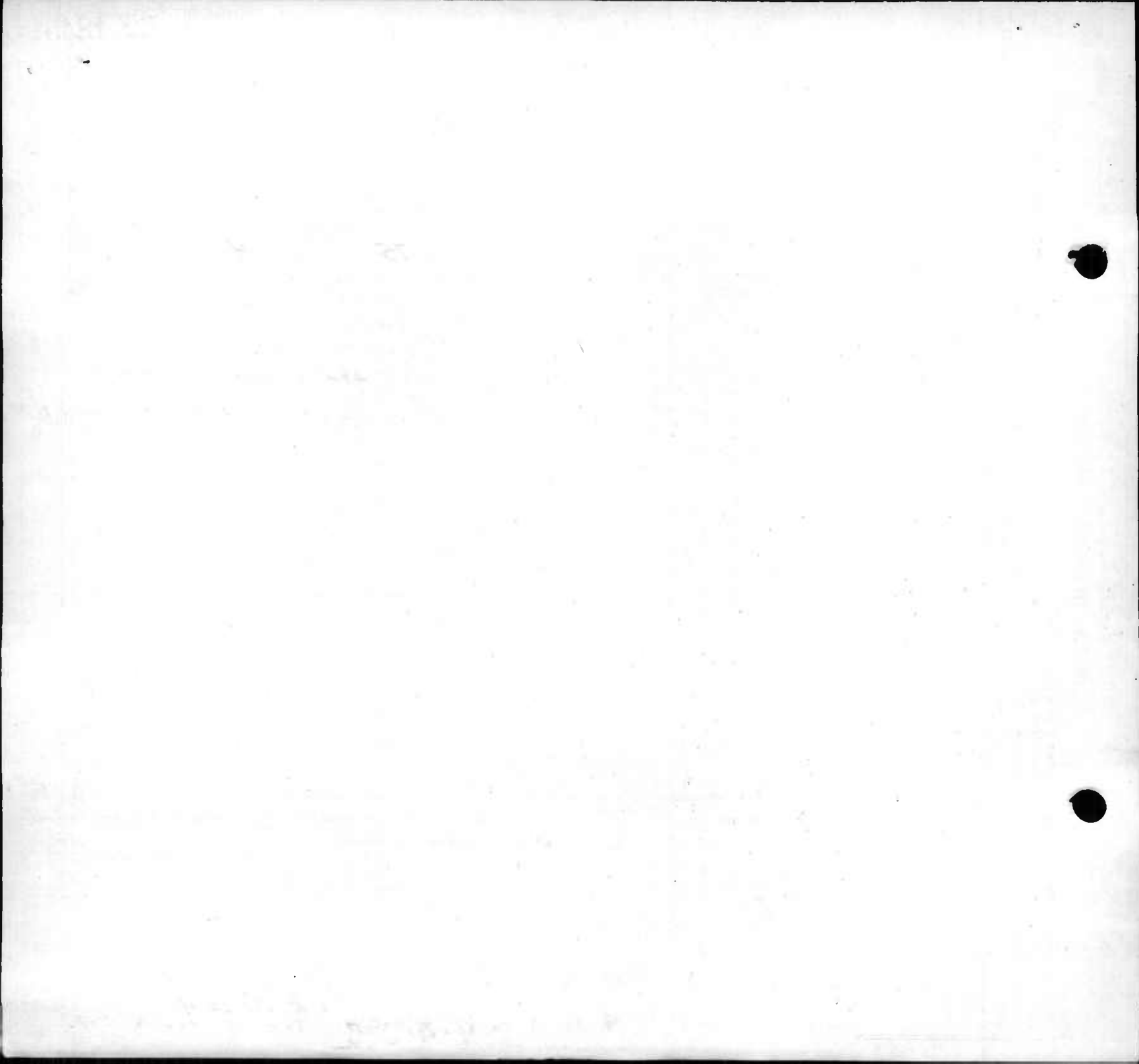
W-426		69 12450		CITY OF BALTIMORE		REG. NO. 69 12450	
BIRTH NO.				CITY OF BALTIMORE			
1. NAME OF DECEASED (Type or Print) <i>Nettie Walker</i>				2. DATE AND HOUR OF DEATH <i>12-14-69</i> <i>6:15</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>ISSUE, MD 5800</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>George Washington Nurs. Home</i> <i>90</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i> 6. RACE <i>Negro</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <i>2/8/1884</i>		9. AGE (In years last birthday) <i>85</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>MD.</i>	
13. FATHER'S NAME <i>Peter Proctor</i>				14. MOTHER'S MAIDEN NAME <i>Sarah Chisley</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>185-01-8144</i>		17. INFORMANT <i>Chart # 797</i>	
18. <i>412.3 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>ARTERIOSCLEROTIC HEART DISEASE</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>GENERALIZED ARTERIOSCLEROSIS</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <i>EMPHYSEMA</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>1 MAY 1969</i> to <i>14 DEC 1969</i> , that (2) (we) last saw the deceased alive on <i>12 DEC 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Richard Tyson, M.D.</i>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>12-14-69</i>	
23C. PHYSICIAN'S NAME (Type) <i>RICHARD TYSON, M.D.</i>				23D. ADDRESS <i>2320 EUTAW AVE. BALTO MD 21217</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12-16-69</i>		24C. NAME OF CEMETERY or CREMATORY <i>MT. CALVARY</i>		24D. LOCATION (City, town, or county) (State) <i>BALTO. MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 17 1969</i>		25B. NAME OF REGISTRAR <i>James E. Taylor, Md.</i>		25C. FUNERAL DIRECTOR'S NAME AND ADDRESS <i>W. R. BAILEY</i> <i>KELSON F. H. 1348 Calhoun St.</i>			

Issue, Md. Charles Co.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-623		69 12451		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12451	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) LILLIAN TRUSTY				2. DATE AND HOUR OF DEATH Dec. 14, 1969 7:45 p. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 1501			
FULL NAME OF HOSPITAL OR INSTITUTION 91 Montebello State Hospital						C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1357 N. Calhoun Street									
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-18-75		9. AGE (In years last birthday) 94		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Abraham Trusty				14. MOTHER'S MAIDEN NAME Rebecca Trusty					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 216-46-0366		17. INFORMANT ADA K. JENKINS ADDRESS Hospital Chart 2907 Woodland Ave.			
18. 174X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of breast ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 years									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 6-30 1966 to 12-14 1969 , that (I) (we) lost saw the deceased alive on 12-14 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Cesar J. Pellerano M.D.						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-14-69	
23C. PHYSICIAN'S NAME (Type) Cesar J. Pellerano M.D.						23D. ADDRESS Montebello State Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-18-69		24C. NAME OF CEMETERY or CREMATORY ARBUTHUS MEM. PK		24D. LOCATION (City, town, or county) (State) BALTO. Md.			
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Valerie E. Taylor		25C. FUNERAL DIRECTOR G.R. BAILEY ADDRESS 1348 CALHOUN ST.					



69 12452

BALTIMORE CITY HEALTH DEPARTMENT

W-452

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12452

BIRTH NO. 69-17154

1. NAME OF DECEASED (Type or Print) Terry Williams				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Lutheran Hospital (DOA)				3. DATE PRONOUNCED DEAD Month Day Year Hour 12 14 69 12:15 P.M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 1606							
6. SEX Female	7. RACE Negro	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH 9-22-69		10. AGE (In years last birthday) 2		E. STREET AND NUMBER 610 Dukeland St.			
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Williams			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME Sandra Williams			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. none		18. INFORMANT ADDRESS Sandra Williams same			
19. E890X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH Conflagration		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
20A. DATE OF OPERATION 0				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? Basement - 610 Dukeland Avenue 1606			
22D. TIME OF INJURY (APPROX.) 12-14-69 11:30A m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject trapped in a house fire.			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher M.D. EXAMINER'S NAME (Type) Russell S. Fisher, M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 12-15-69							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-17-69		24C. NAME OF CEMETERY or CREMATORY Mt. Auburn Cem.		24D. LOCATION (City, town, or county) (State) Balto. Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert S. Fisher, M.D.		25C. FUNERAL DIRECTOR V Bailey ADDRESS Klison, F.H. 1348 Calhoun St.			

W/A

SLIDE

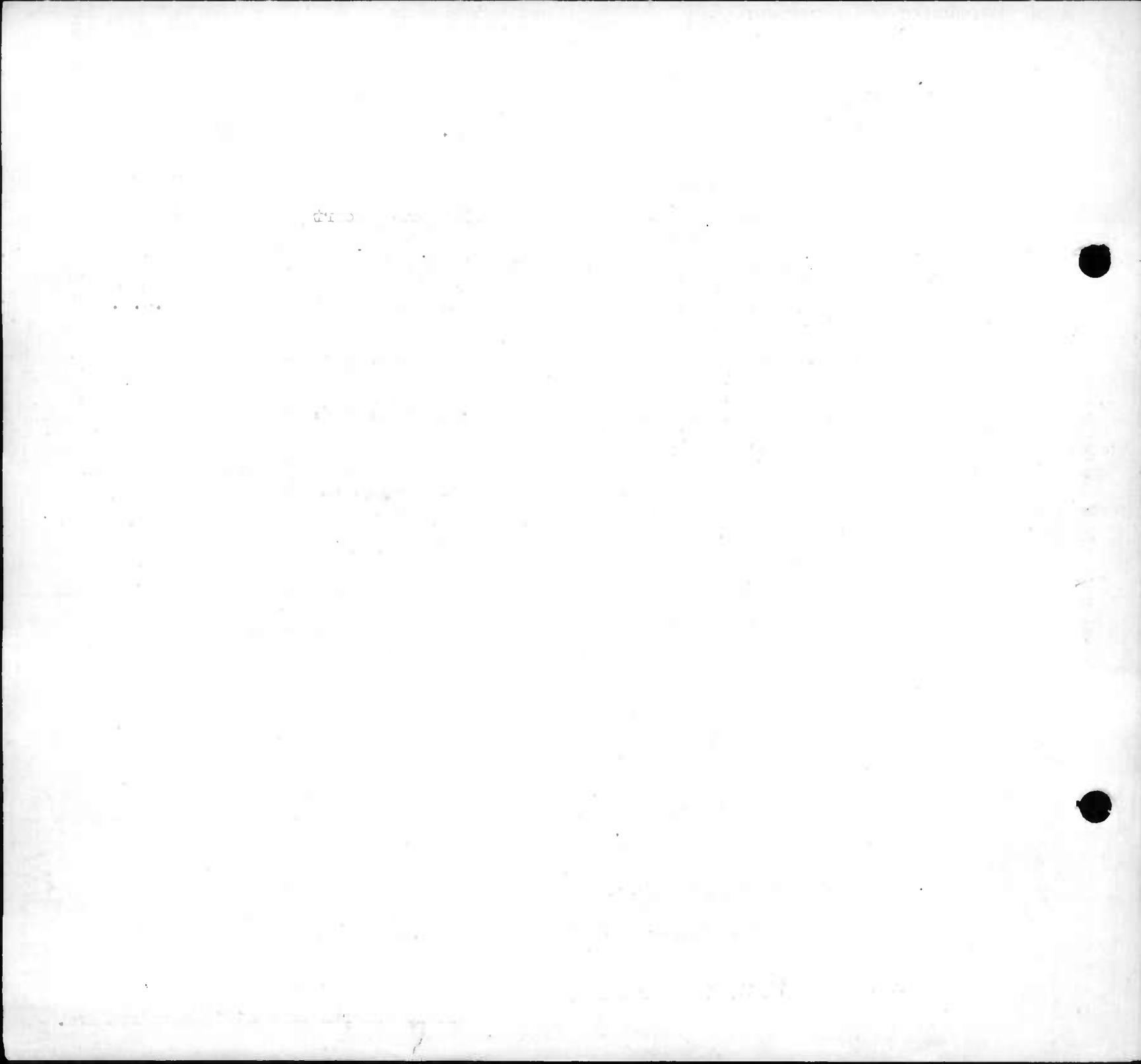
FOR

USE

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>69 12453</u>	
P-620 69 12453				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>ANNA PARKS</u>		2. DATE AND HOUR OF DEATH <u>December 14, 1969 7:45 P. M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>38 UNIVERSITY HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>337 Spring Court</u>			
5. SEX <u>F</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>3/29/89</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ADOLPH PARKS</u>		14. MOTHER'S MAIDEN NAME <u>Emma KACZALZ</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Mr. Alfred Parks, 2814 Plainfield Road</u>	
18. <u>444.2</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>PERFORATED VISCUS E peritonitis</u> (B) <u>MESENTERIC VASCULAR OCCLUSION</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>HOURS</u> <u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>JAUNDICE, UNKNOWN ETIO.</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (it) (this hospital) attended the deceased from <u>12/13</u> 19 <u>69</u> to <u>12/14</u> 19 <u>69</u> , that (it) (we) lost saw the deceased alive on <u>12/14</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>I. Frank Hartman M.D.</u> 23C. PHYSICIAN'S NAME (Type) <u>I. FRANK HARTMAN M.D.</u>				23B. DATE SIGNED <u>12/14/69</u>	
23D. ADDRESS <u>Univ of Md Hosp</u>		23E. FUNERAL DIRECTOR ADDRESS <u>Witzke Funeral Home 4101 Edmondson Ave.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12/17/69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Crestlawn</u>	
24D. LOCATION (City, town, or county) <u>Carroll County, Maryland</u>		24E. (State)			



C-162 C-612 69 12454
CERTIFICATE OF DEATH

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

CATHERINE M. CIERPISZ (Cierpisz)

2. DATE AND HOUR OF DEATH

12/15/69 2:40 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF
HOSPITAL OR
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET
ADDRESS OR LOCATION)

31

BALTIMORE CITY HOSPITALS

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

129 N. Kenwood Avenue 21224 007

5. SEX

Female

6. RACE

White

7. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH

1-29-01

9. AGE (In years
last birthday)

68

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Packer

10B. KIND OF BUSINESS OR INDUSTRY

Automobile Mfg.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Simon Stachorowski

14. MOTHER'S MAIDEN NAME

Mary Gilewski

15. Was Deceased Ever in U. S. Armed Forces?
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL
SECURITY NO.

219-10-5724

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH-Records Baltimore, Maryland 21224

18.

43691

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving
rise to the above cause (A) stating the
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

pneumonia

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 days

(B)

DUE TO, OR AS A CONSEQUENCE OF:

CVA

5 days

(C)

5 days

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART I (A).

Myocardial Infarction

5 days

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg.,
etc.)21C. WHERE DID
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME
OF INJURY
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At ☐
WorkNot While ☐
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (H) (this hospital) attended the deceased from 12/10/69 to 12/15/69, and that (I) (we) last saw the deceased alive on 12/15/69, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

John R. Neefe, Jr. MD

Attending
Phys. ☐Med.
Director ☐Staff
Phys. ☒

23B. DATE SIGNED

12/15/69

23C. PHYSICIAN'S
NAME (Type)

John R. Neefe, Jr.

MD

23D. ADDRESS

4940 Eastern Avenue

BCH- Baltimore, Maryland 21224

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12/19/69

24C. NAME OF CEMETERY or CREMATORY

St. Stanislaus

24D. LOCATION

Baltimore, Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

DEC 17 1969

25B. NAME OF REGISTRAR

John R. Neefe, Jr.

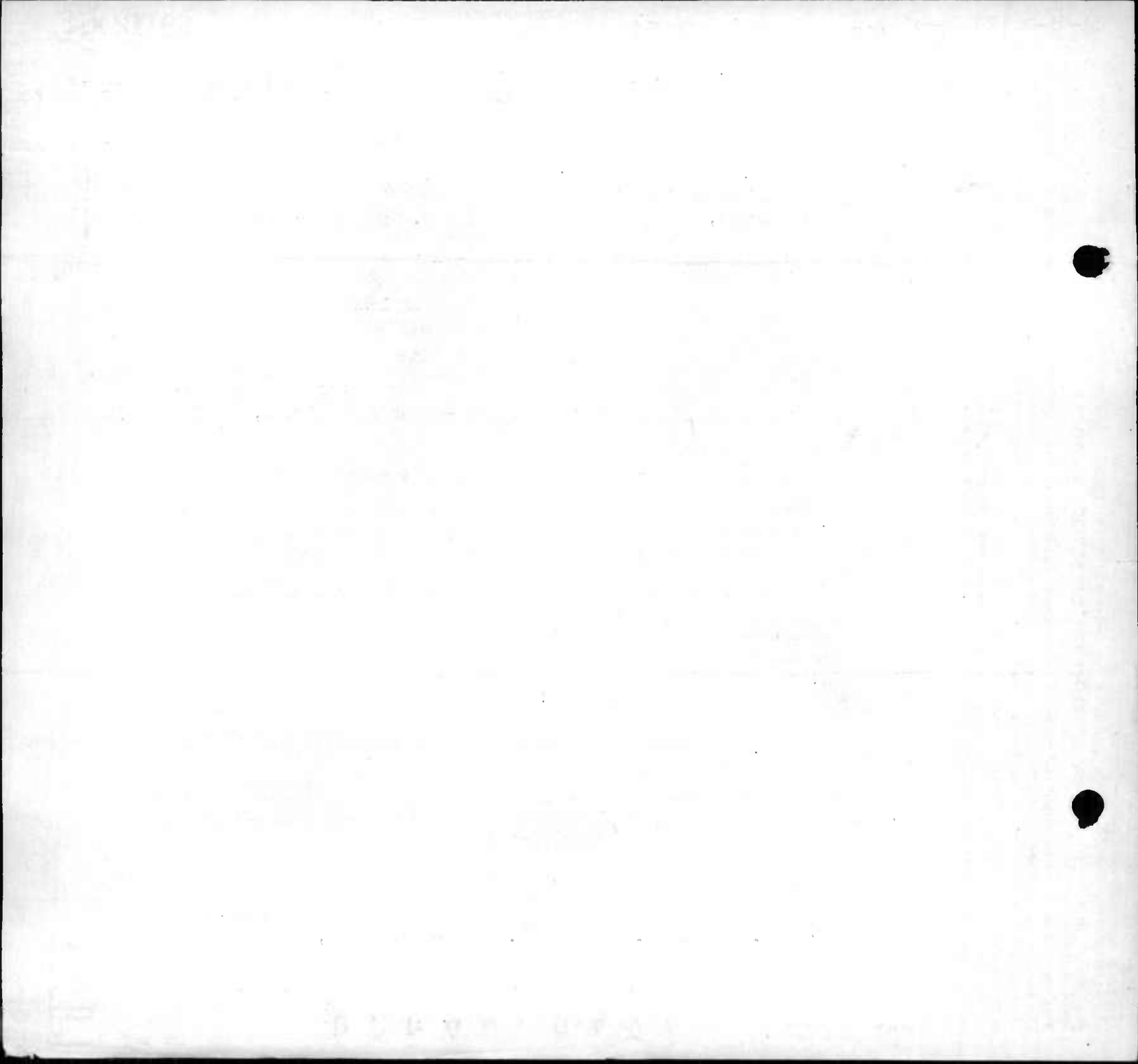
25C. FUNERAL DIRECTOR

M. F. SADOWSKI & SONS, 1808 EASTERN AVE

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

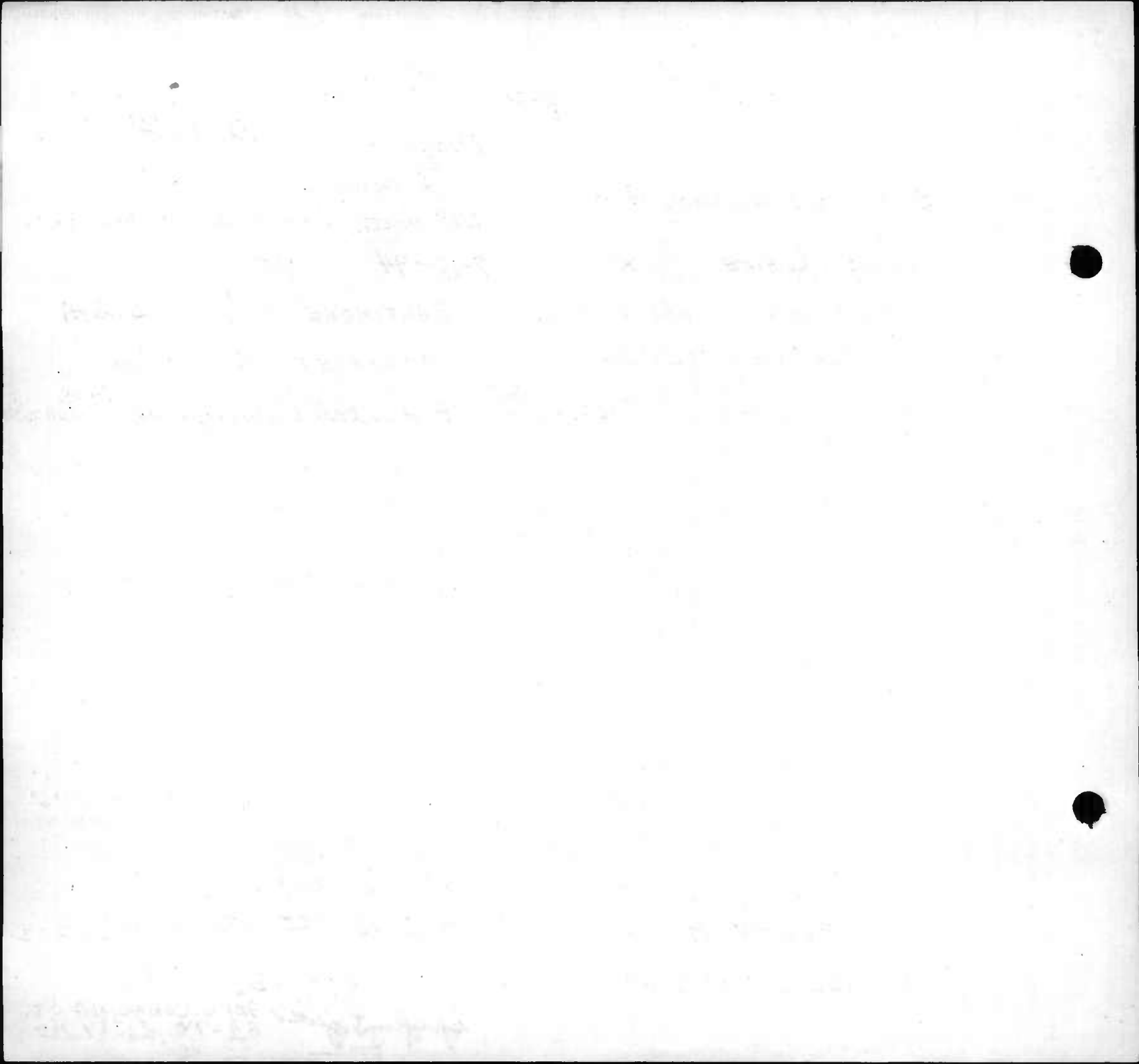
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

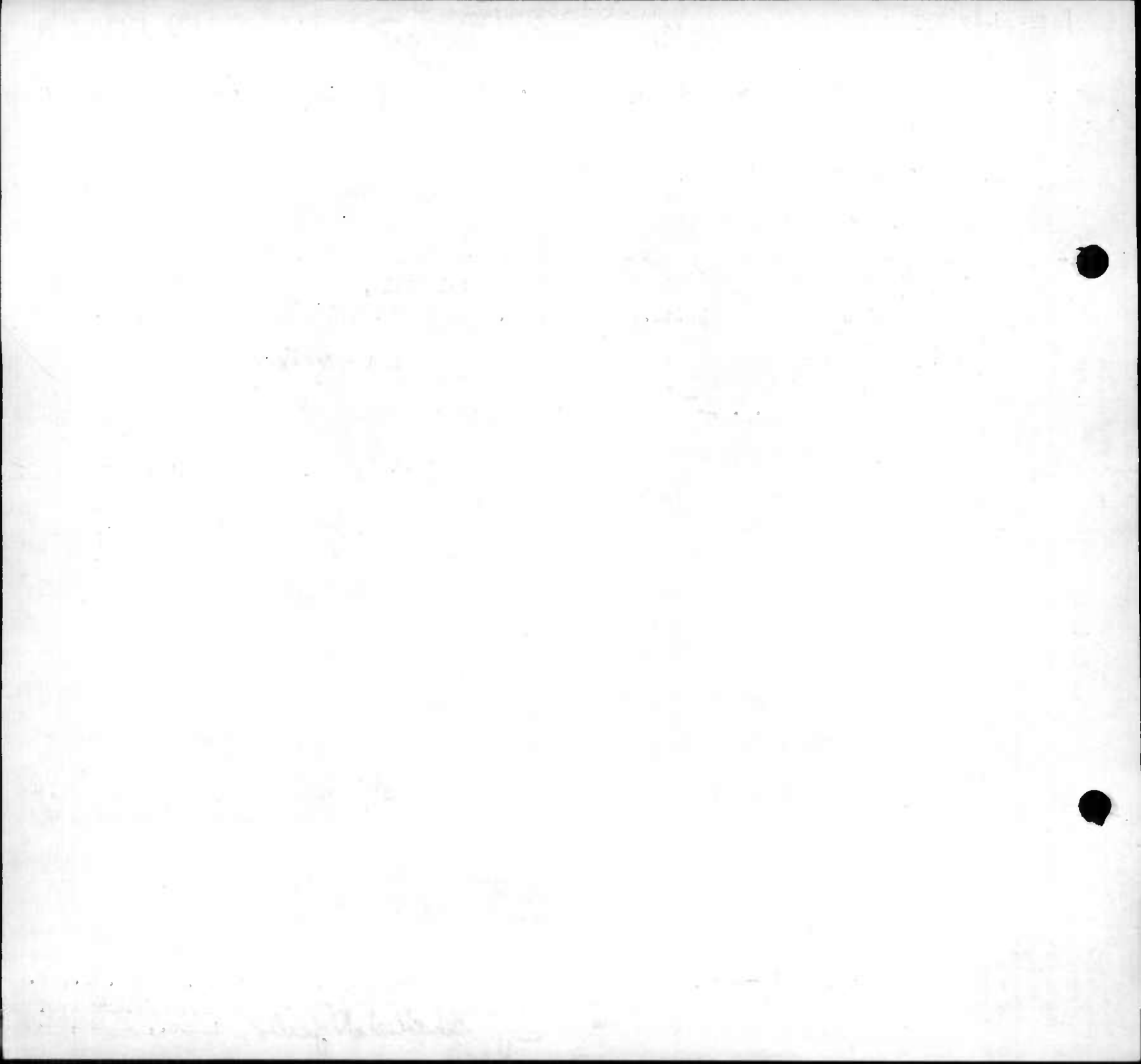
W-424		69 12455		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12455	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Margaret K. Woodshleger</i>			
2. DATE AND HOUR OF DEATH <i>12-15-69 645 P.M.</i>				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <i>Bottom Hill Nursing Home</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Bottom Hill Nursing Home</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1113 South Bouldin St. #2124</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-10-94</i>	9. AGE (In years last birthday) <i>75</i>	10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>RETIRED</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HOUSE WORK</i>
11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>CASPER KLOES</i>				14. MOTHER'S MAIDEN NAME <i>MARGARET SCHNYDER</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>22003-1227</i>		17. INFORMANT <i>Bottom Hill Nursing Home</i>		ADDRESS <i>1400 Johns St.</i>	
18. <i>412.31</i>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>cerebral thrombosis</i>		12/19/69			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF:		years			
		(C) <i>arteriosclerosis, gen</i>		years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>11/7 1969</i> to <i>12/15 1969</i> , that (I) (we) last saw the deceased alive on <i>12/15 1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Al Martin</i>				23B. DATE SIGNED <i>12/16/69</i>			
23C. PHYSICIAN'S NAME (Type) <i>ALLAN H. MACHT M.D.</i>				23D. ADDRESS <i>2 E. Red St Balto Md, 21202</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>12-18-69</i>		24C. NAME OF CEMETERY OR CREMATORY <i>MEADOWRIDGE CEM.</i>		24D. LOCATION (City, town, or county) (State) <i>ELKRIE, MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 17 1969</i>		25B. NAME OF REGISTRAR <i>Charles E. Seiler</i>		25C. FUNERAL DIRECTOR <i>Charles E. Seiler</i>		ADDRESS <i>901 S. CONKLING ST. BALTO, MD 21224</i>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

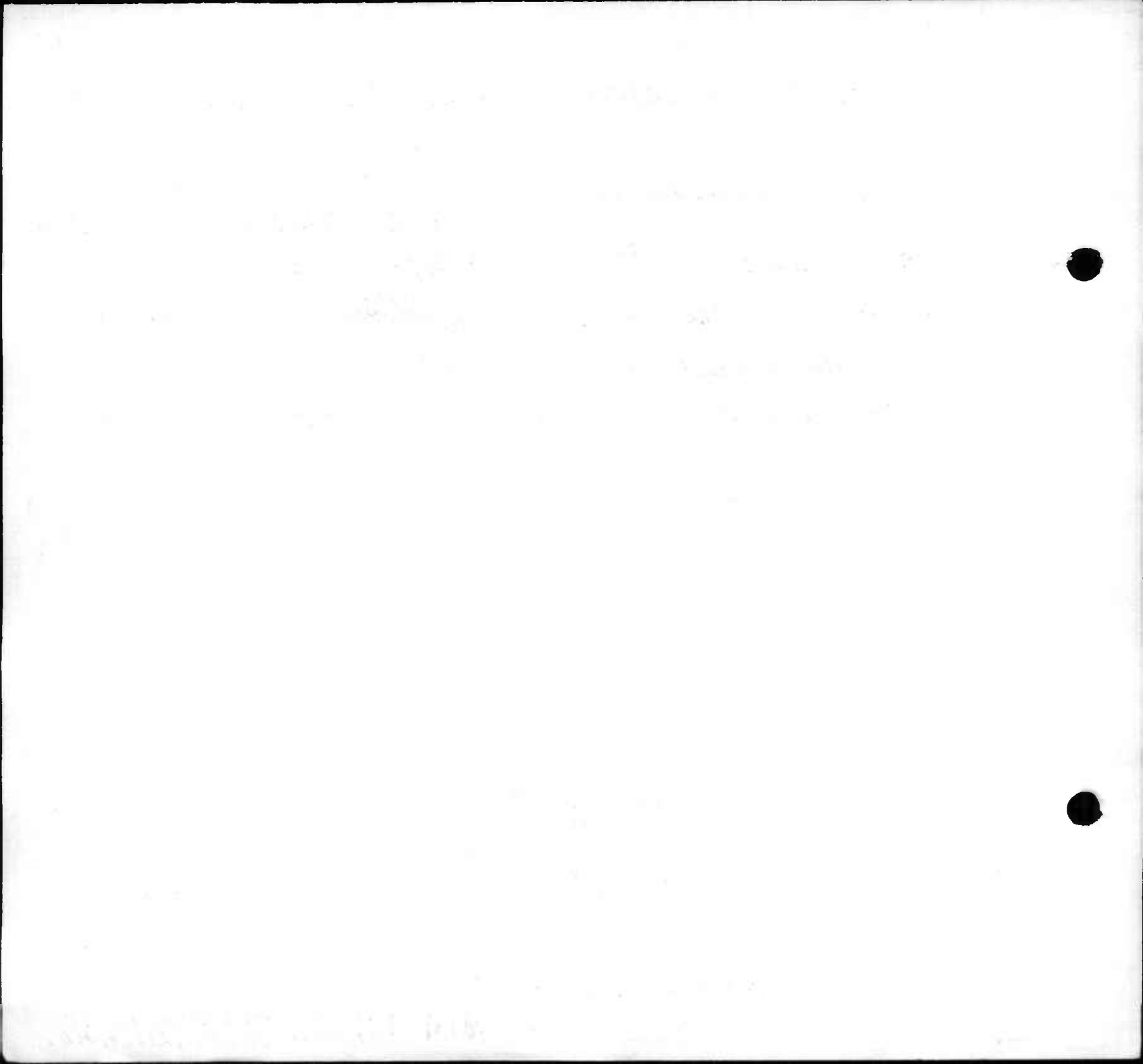
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12456	
F-630 69 12456		CERTIFICATE OF DEATH	
1. NAME OF DECEASED John Ford (Type or Print) John H. Ford		2. DATE AND HOUR OF DEATH 12/14/69 2:10 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BALTIMORE CITY HOSPITALS 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived if institution; residence before admission) A. STATE Maryland B. COUNTY 2744 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3105 HAMILTON AVENUE 21218	
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-22-96
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Balto. Gas and Elec.	9. AGE (In years last birthday) 73
11. BIRTHPLACE (State or foreign country) Chilfield, Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Ford		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W.W. I		16. SOCIAL SECURITY NO. 212-05-4314	
17. INFORMANT BCH: Records Baltimore, Maryland 21224		ADDRESS 4940 Eastern Avenue	
18. 569.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Ventricular Fibrillation - (B) DUE TO, OR AS A CONSEQUENCE OF: Acute MI (C) GI Hemorrhage		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hrs 4 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (A) Coronary Artery Disease			
19A. DATE OF OPERATION 2/1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/13 19 69 to 12/14 19 69 , that (I) (we) last saw the deceased alive on 12/14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Jack D. McCue DEGREE		23B. DATE SIGNED 12-14-69	
23C. PHYSICIAN'S NAME (Type) Jack McCue		23D. ADDRESS BALTIMORE CITY HOSPITALS 21224 4940 Eastern Avenue Baltimore, Maryland	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 12-18-69	24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park	24D. LOCATION (City, town, or county) (State) 2901 Taylor Ave., Balto. Co., Md.
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969	25B. NAME OF REGISTRAR Robert E. J. [unclear]	25C. FUNERAL DIRECTOR Charles D. Geiler, 6224 Eastern Ave. Balto., 21224, Md.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

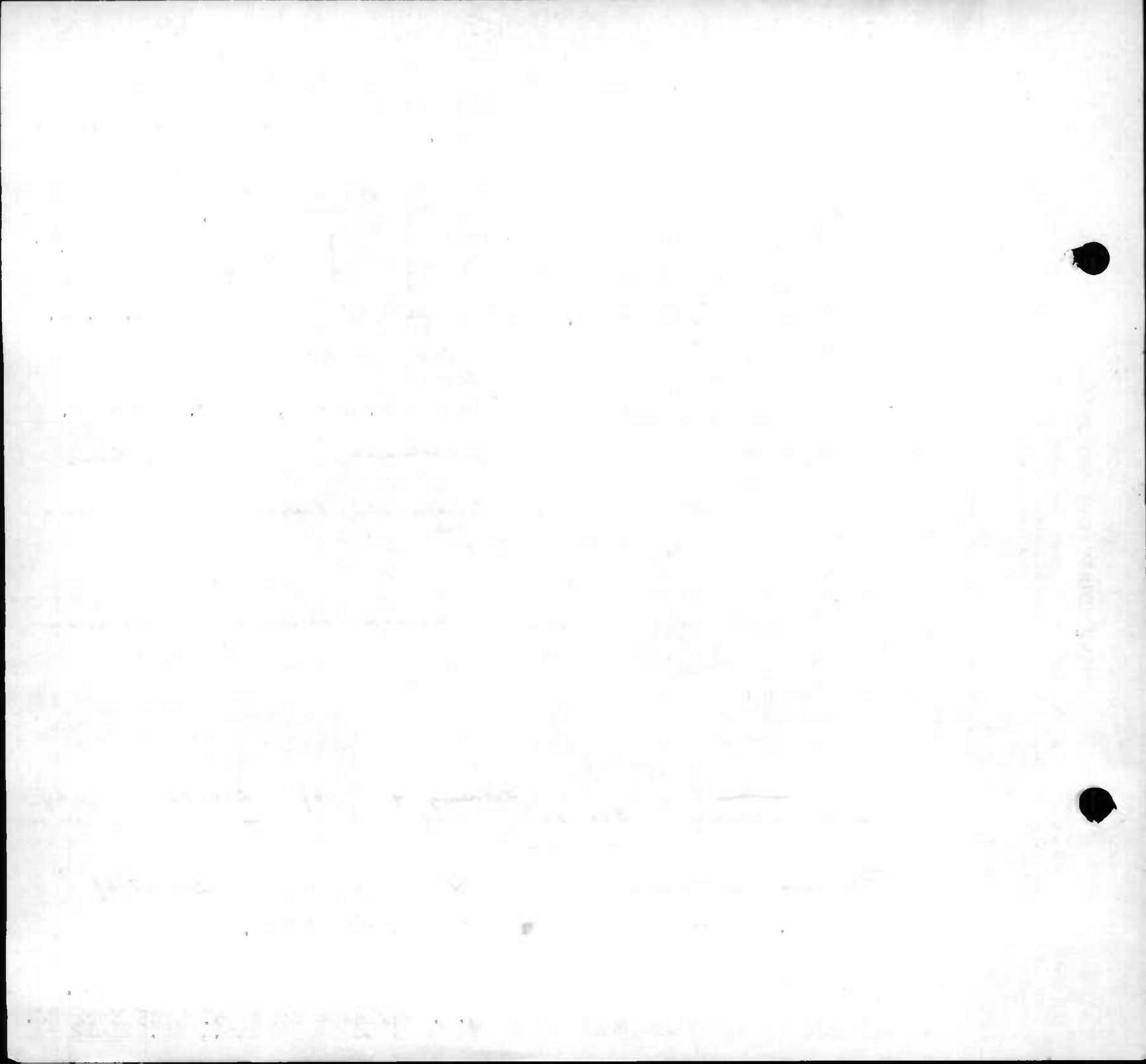
R-352		69 12457		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12457	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) STEVEN STEVE G. RADONSKY-RADOMSKI-RADOMSKY				2. DATE AND HOUR OF DEATH Dec 14, 1969 5:40 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD SOUTH BALTIMORE GENERAL HOSPITAL 43				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2611		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER 816 S. HIGHLAND AVE. #21224					
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/2/93	9. AGE (In years last birthday) 76	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY BETHLEHEM STEEL CO		11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME FRANK RADOMSKI				14. MOTHER'S MAIDEN NAME UNKNOWN					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES		16. SOCIAL SECURITY NO. W.W.I. 216-10-3149		17. INFORMANT FRANCES RADOMSKI		ADDRESS SAME.			
18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 151.9 I PNEUMONIA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CAUSE OF DEATH CARCINOMA OF THE STOMACH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (1) (this hospital) attended the deceased from 12/5 19 69 to 12/14 19 69 that (1) (we) last saw the deceased alive on 12/14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.									
23A. SIGNATURE William Eric Sohn M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/14/69			
23C. PHYSICIAN'S NAME (Type) William Eric Sohn				23D. ADDRESS 4402 COLBOENE RD. BALTO, MD 21229					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-18-69		24C. NAME OF CEMETERY or CREMATORY ST. STANISLAUS CEM.		24D. LOCATION (City, town, or county) (State) 6515 BOSTON AVE. BALTO., MD.			
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. [illegible]		25C. FUNERAL DIRECTOR Charles S. Geiler ADDRESS 901 S. CONKLING ST. BALTO., MD.					



FUNERAL DIRECTOR: IMPORTANT

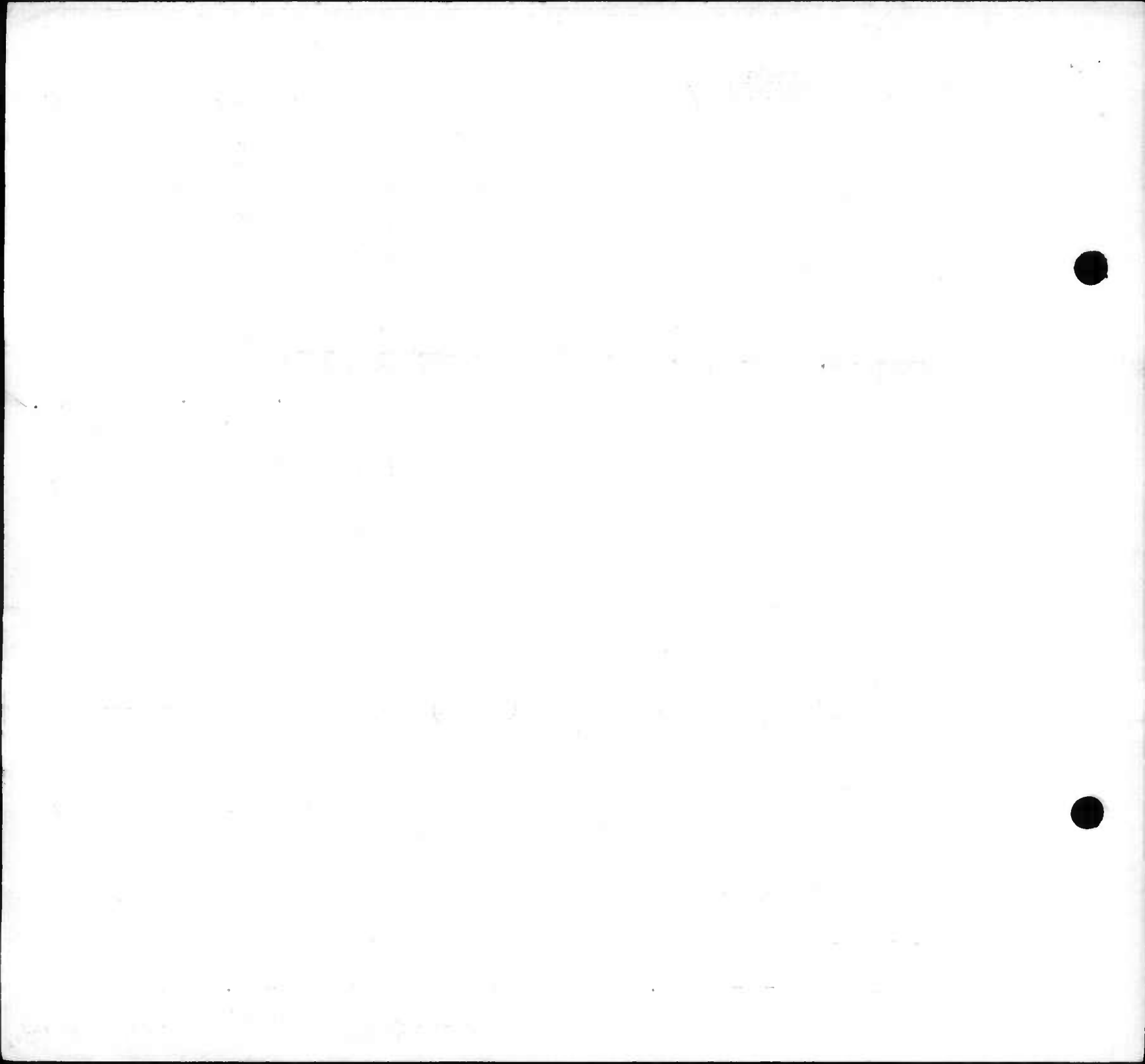
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> C-560 69 12458 </div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 69 12458	
BIRTH NO. 1		1. NAME OF DECEASED (Type or Print) Mary L. Connor		2. DATE AND HOUR OF DEATH December 16, 1969 1:30 P.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em;">90</div> Gould Convalescerium		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 2759		C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F 6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/1/1888 9. AGE (In years last birthday) 81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10B. KIND OF BUSINESS OR INDUSTRY Drug Manufacturer		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Michael Connor		14. MOTHER'S MAIDEN NAME Margaret Murray		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-3789		17. INFORMANT Robert W. Payne, 206 E. Eager St.	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) Coronary Occlusion		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerosis Cordis Vascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Wernic Fibroid Tumor		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from February 4 19 69 to Dec. 16 19 69 , that (I) (we) last saw the deceased alive on Dec. 16 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
23A. SIGNATURE Philibert Artigiani		23B. DATE SIGNED Dec. 17/69		23C. PHYSICIAN'S NAME (Type) Dr. Philibert Artigiani	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/19/69		24C. NAME OF CEMETERY OR CREMATORY New Cathedral	
24D. LOCATION Baltimore		24E. ADDRESS 2305 Mayfield Ave.		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969	
25B. NAME OF REGISTRAR H.W. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25D. ADDRESS 4905 York Rd. Balto., Md. 21212	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-450		69 12459		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X		REG. NO.		69 12459	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Stanley Raymond Clem				2. DATE AND HOUR OF DEATH 12-11-69 1:12:45 PM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY FREDRICK 60-11									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U of Md				C. CITY OR TOWN FREDERICK				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
E. STREET AND NUMBER 1493-W-10th St.													
5. SEX M		6. RACE CA		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1952 8-21-52		9. AGE (In years last birthday) 17		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction worker				10B. KIND OF BUSINESS OR INDUSTRY Stone & masonry				11. BIRTHPLACE (State or foreign country) MD				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John M. Clem				14. MOTHER'S MAIDEN NAME Bowers Charlotte Bowers									
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mother Charlotte B. Clem				ADDRESS 1493 W. 10th St. Frederick-Md.			
18. 747.61 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH intracerebral Hematoma				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12-10-69					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: A-V malformation									
				(B) DUE TO, OR AS A CONSEQUENCE OF:									
				(C)									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).													
19A. DATE OF OPERATION 12-10-69				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED above				20A. AUTOPSY? (Yes or No) YES				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 12-10-69				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 12-10-69 to 12-11-69				that (I) (we) last saw the deceased alive on 12-11-69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Daniel H. White				23B. DATE SIGNED 12-11-69									
23C. PHYSICIAN'S NAME (Type) DANIEL H. WHITE				23D. ADDRESS U of Md Hospital Balti									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-15-69				24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery				24D. LOCATION (City, town, or county) (State) Frederick-Md. 21701	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969				25B. NAME OF REGISTRAR Robert E. White, M.D.				25C. FUNERAL DIRECTOR By E. T. Whitmore & Son				ADDRESS Frederick, Md.	



H. 325

H-325

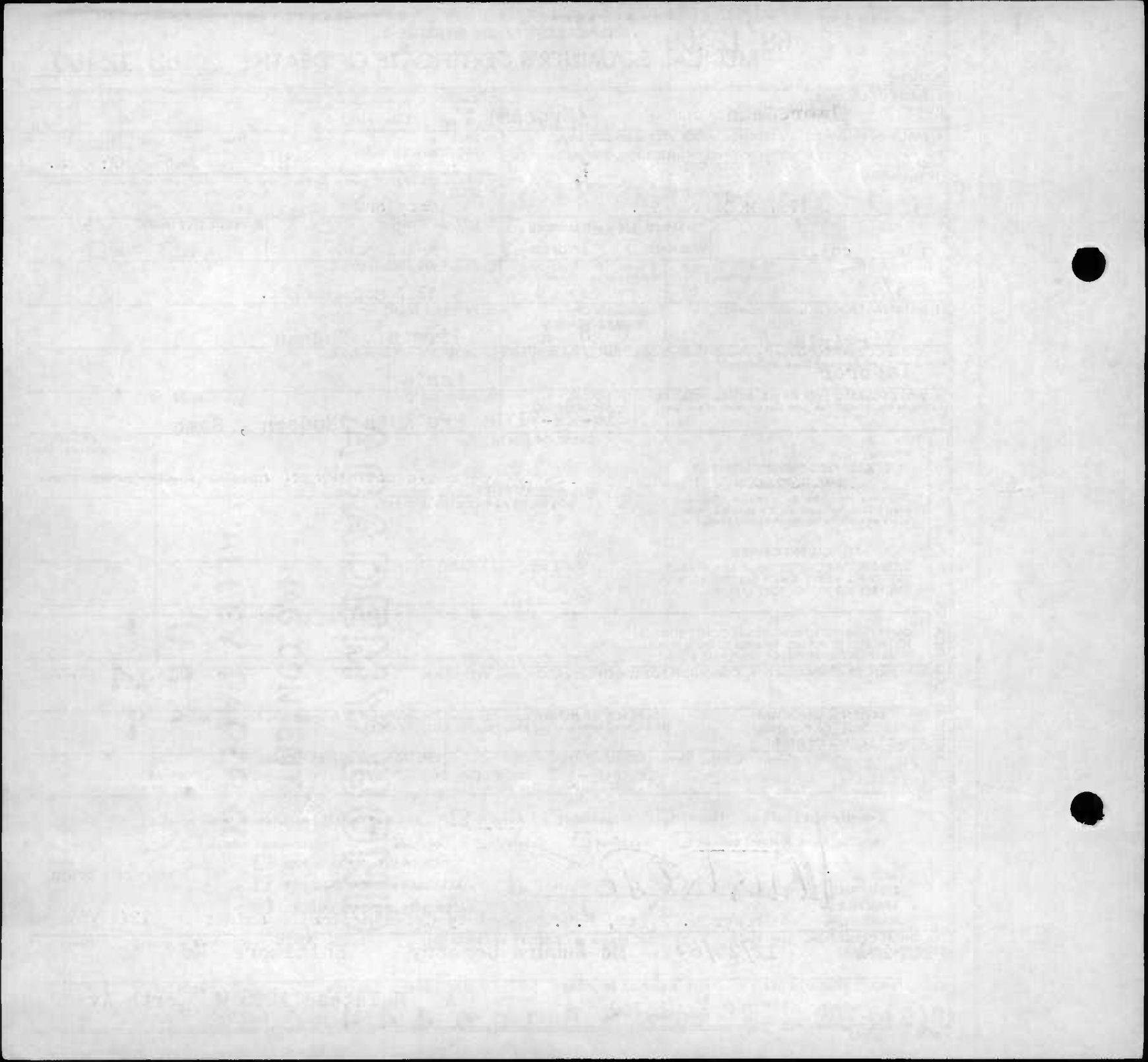
69 12460

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12460

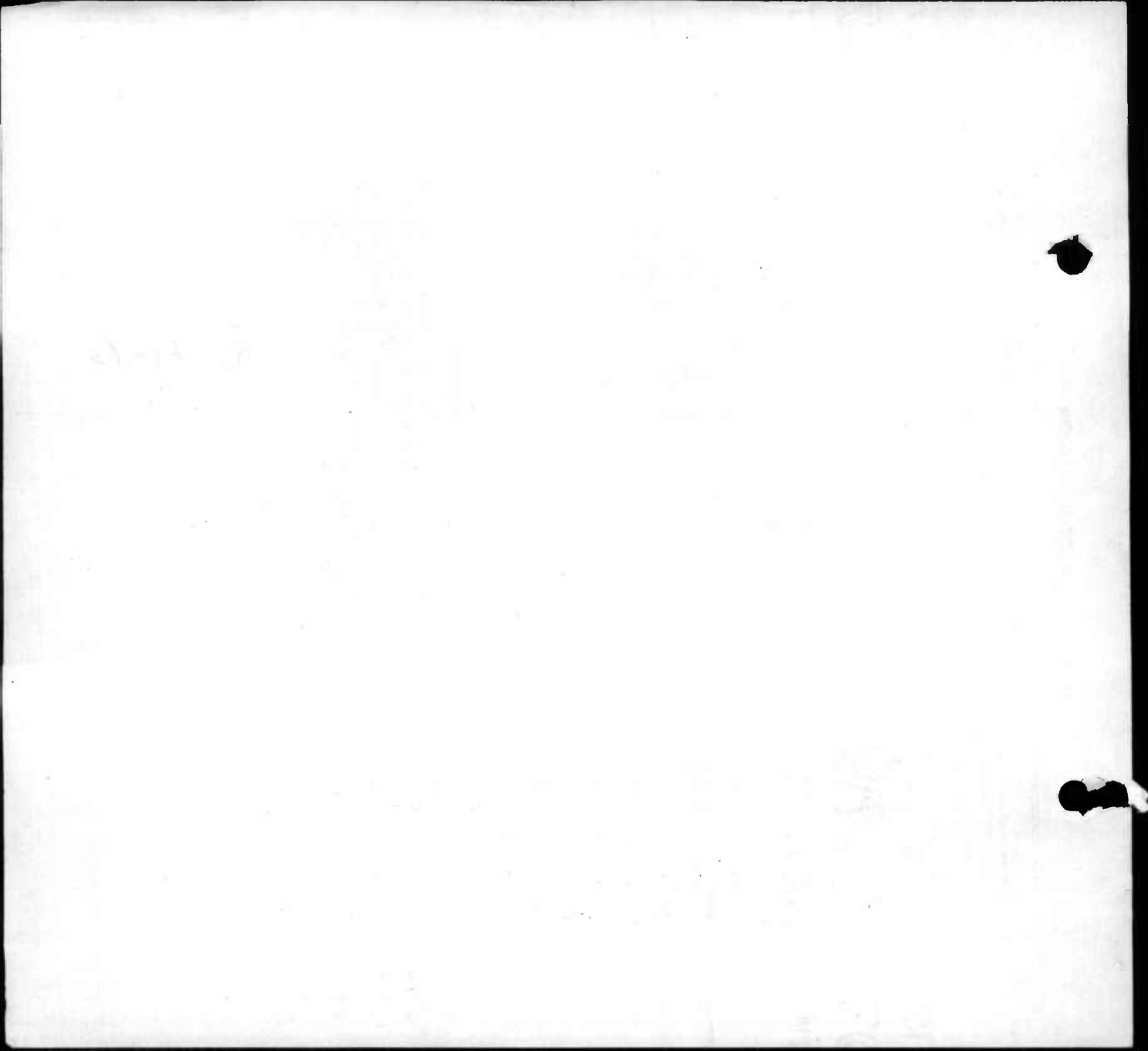
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Elmer John Hutson (Hudson)		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 1737 McCulloh St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 14 69 7:45 a. M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1402	
6. SEX male	7. RACE colored	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 5/08		10. AGE (In years last birthday) 59	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Jimmie Hudson		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Nanie	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 216-28-7179		18. INFORMANT Mrs Ruth Hudson, Same	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2/20/69		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) yes	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Werner U. Spitz M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. Deputy Chief Medical Examiner DATE SIGNED 12/14/69 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/20/69		24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cemetery	
24D. LOCATION (City, town or county) (State) Baltimore Md		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR W. E. Raben	
25C. FUNERAL DIRECTOR A Halstead		25D. ADDRESS 1206 W North Ave			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12461	
L-340 69 12461		CERTIFICATE OF DEATH			
BIRTH NO. 69-18713		1. NAME OF DECEASED (Type or Print) STACIE LITTLE			
2. DATE AND HOUR OF DEATH 12-13-69 12:05A M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) SINAI HOSPITAL OF BALTO. BALTO. MD. 21215		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Md. B. COUNTY BALTO.		C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 626 MELVILLE		5. SEX F 6. RACE B 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-69 9. AGE (In years lost birthday) 2 12	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md. 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert		14. MOTHER'S MAIDEN NAME FRANCES Richards		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO.		17. INFORMANT m Robert Little		ADDRESS 626 Melville	
18. 75-9.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC FAILURE		3 days	
		(B) PNEUMONIA (ASPIRATION)		1 day	
		(C) CHROMOSOMAL ABNORMALITY-TRISOMY 16/18		Congenital	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		POSSIBLE Tracheo esophageal fistula			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from Dec 1, 1969 to Dec. 13, 1969, that (1) (the) last saw the deceased alive on Dec 12 19 69 and that in (my) (the) opinion death occurred on the date and hour and from the causes stated above. (1) (the) (did) (did not) view the body after death.					
23A. SIGNATURE Edward N Zissman M.D.		23B. DATE SIGNED 12/13/69		23C. PHYSICIAN'S NAME (Type) EDWARD N. ZISSMAN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) B		24B. DATE 12/15/69		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary C. Bldg Md	
24D. LOCATION (City, town, or county) (State)		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. [unclear]	
25C. FUNERAL DIRECTOR [unclear]		25D. ADDRESS 512 N. Carroll [unclear]		25E. [unclear]	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-600		69 12462		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 69 12462	
1. NAME OF DECEASED (Type or Print) Mary M. Perry				2. DATE AND HOUR OF DEATH December-11th, 1969 645 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION 00 1115 West Lanvale Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1601 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1115 West Lanvale Street			
5. SEX Female	6. RACE American	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 9/4/1879	9. AGE (In years last birthday) 90	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Buchingham County Va.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Buchingham County Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Wyette Jones				14. MOTHER'S MAIDEN NAME Betty ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. WA 170971		17. INFORMANT Annie E. Waters	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) 412.3 I atrio Sclerosis myocarditis				CAUSE OF DEATH 5 years 5 years		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION none		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED none		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <input type="checkbox"/>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 3-13-1968 to 12-11-1969 , that (I) (we) lost saw the deceased alive on 11-29-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE John E. T. Camper	
23B. PHYSICIAN'S NAME (Type) JOHN E. T. CAMPER		23C. ADDRESS 639 N. Carey St. Baltimore, Md.		23D. DATE SIGNED 12-12-69		23E. M.D. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/13/69		24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Taylor, Md.		25C. FUNERAL DIRECTOR Stetson H. Wilson		25D. ADDRESS 1913 W. Balto. St	

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P-362 69 12463 BALTIMORE CITY HEALTH DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 69 12463

BIRTH NO.		1. NAME OF DECEASED (Type or Print) (Monroe) Dorothy M. Patterson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1543 N. Gilmore St.		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 16 69 8:10 a. m.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 1501	
6. SEX female	7. RACE colored	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 12-28-1919		10. AGE (In years last birthday) 49	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF U.S.A.
13. FATHER'S NAME Louis Monroe		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME Josephine Monroe	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		17. SOCIAL SECURITY NO.		18. INFORMANT Mr. Emory Patterson	
19. 412.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Hypertensive and arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner DATE SIGNED 12/16/69					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-20-69		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.	
25B. NAME OF REGISTRAR Robert E. J. [unclear]		25D. ADDRESS 1701 Laurens Street			

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THE UNIVERSITY OF CHICAGO

VALLEY CHAPTER CO

RAIL VOUCHER

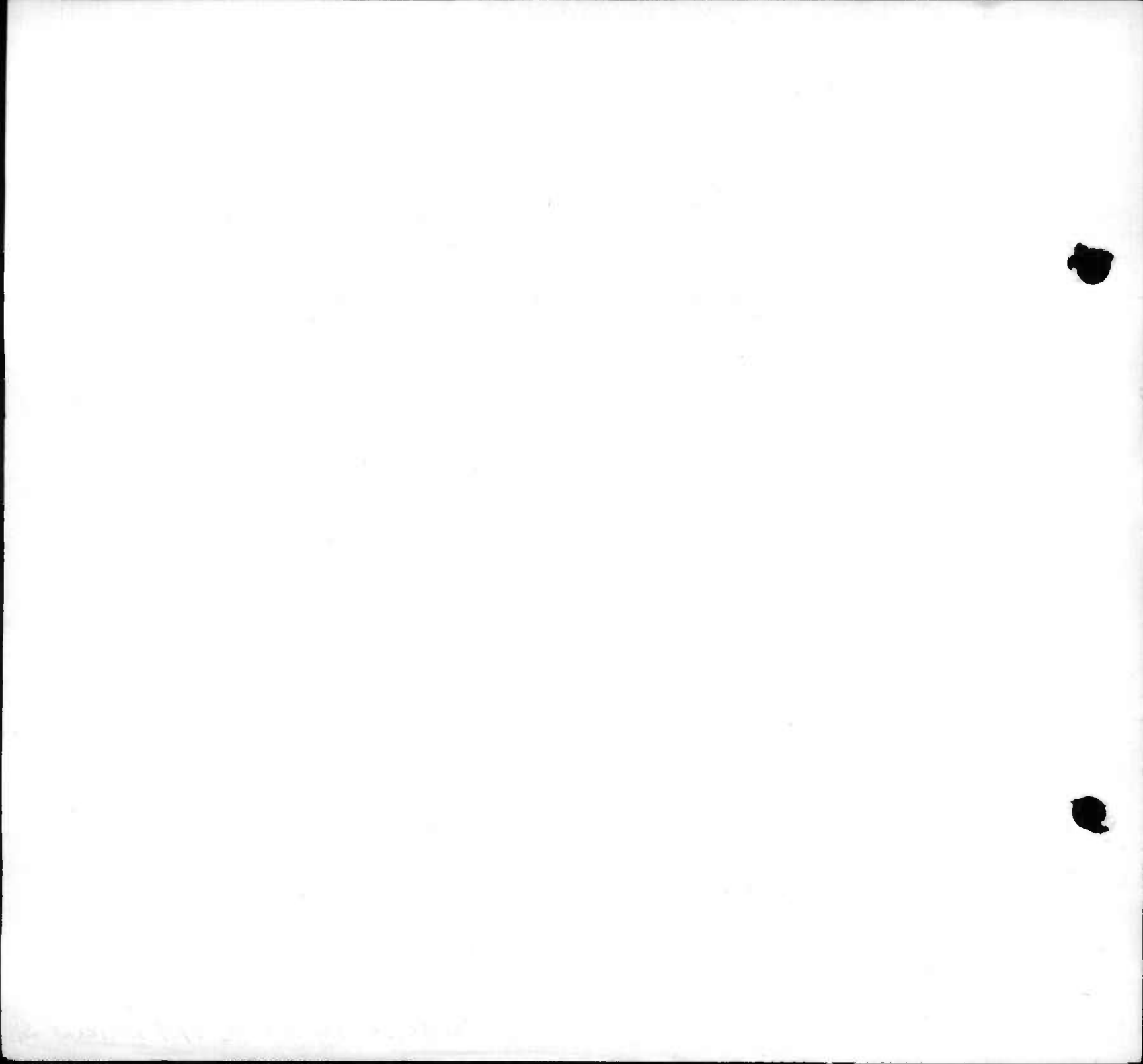
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-620		69 12464		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12464	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) CHARLES ROBERT AYERS		2. DATE AND HOUR OF DEATH Dec. 14, 1969		5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Montebello State Hospital		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE Md.		B. COUNTY 1304	
				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2844 Parkwood Dr.			
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-9-13	9. AGE (In years last birthday) 56	10. If Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction work		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Painter, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Isaac Ayers				14. MOTHER'S MAIDEN NAME Mary Ayers			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown				16. SOCIAL SECURITY NO. 30-177-212130		17. INFORMANT Hospital Chart	
18. 398X I				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Rheumatic heart disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Rheumatic fever DUE TO, OR AS A CONSEQUENCE OF:		Years	
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 3-6 19 69 to 12-14 19 69 that (I) (we) last saw the deceased alive on 12-14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Cesar J. Polkerano M.D.				23B. DATE SIGNED 12-14-69		23C. PHYSICIAN'S NAME (Type) Cesar J. Polkerano M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/18/69		24C. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Herbert F. H.		ADDRESS 1701 Laurens St.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 69 12465		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		Registered No. 69 12465	
1. NAME OF DECEASED (Type or Print) WILLIAM BROWN		2. DATE AND HOUR OF DEATH December 15, 1969			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2207 Clifton Avenue		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1504 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 2207 Clifton Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-14-1895	9. AGE (In years last birthday) 74	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Beth-Steel		11. BIRTHPLACE (State or foreign country) Chestertown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Joseph H. Brown		
14. MOTHER'S MAIDEN NAME Unk.			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS Mrs. Camilla Brown 2207 Clifton Avenue		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.1 H.C.V.D. A.S.H.D. Severe Cachexia		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH not determined	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II N/A			
19A. DATE OF OPERATION N/A		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? N/A		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) N/A			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location) N/A			
21D. TIME OF INJURY (APPROX.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> N/A		21F. HOW DID INJURY OCCUR? N/A	
22. I certify that (I) (this hospital) attended the deceased from 12/11/69 to 12/15/69 and that (I) (we) last saw the deceased alive on 12/11/69 and that in (my) (our) opinion death occurred on the date 12/15/69 and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE U. Ray Jr.		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 12/16/69	
23C. PHYSICIAN'S NAME (Type) U. Ray Jr.		23D. ADDRESS 2225 W North		23E. CITY, STATE, ZIP Baltimore, Maryland 21216	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-18-69		24C. NAME OF CEMETERY or CREMATORY Mount Auburn Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969			
25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS MORTON & DYETT FUNERAL HOME 1701 Laurens St			

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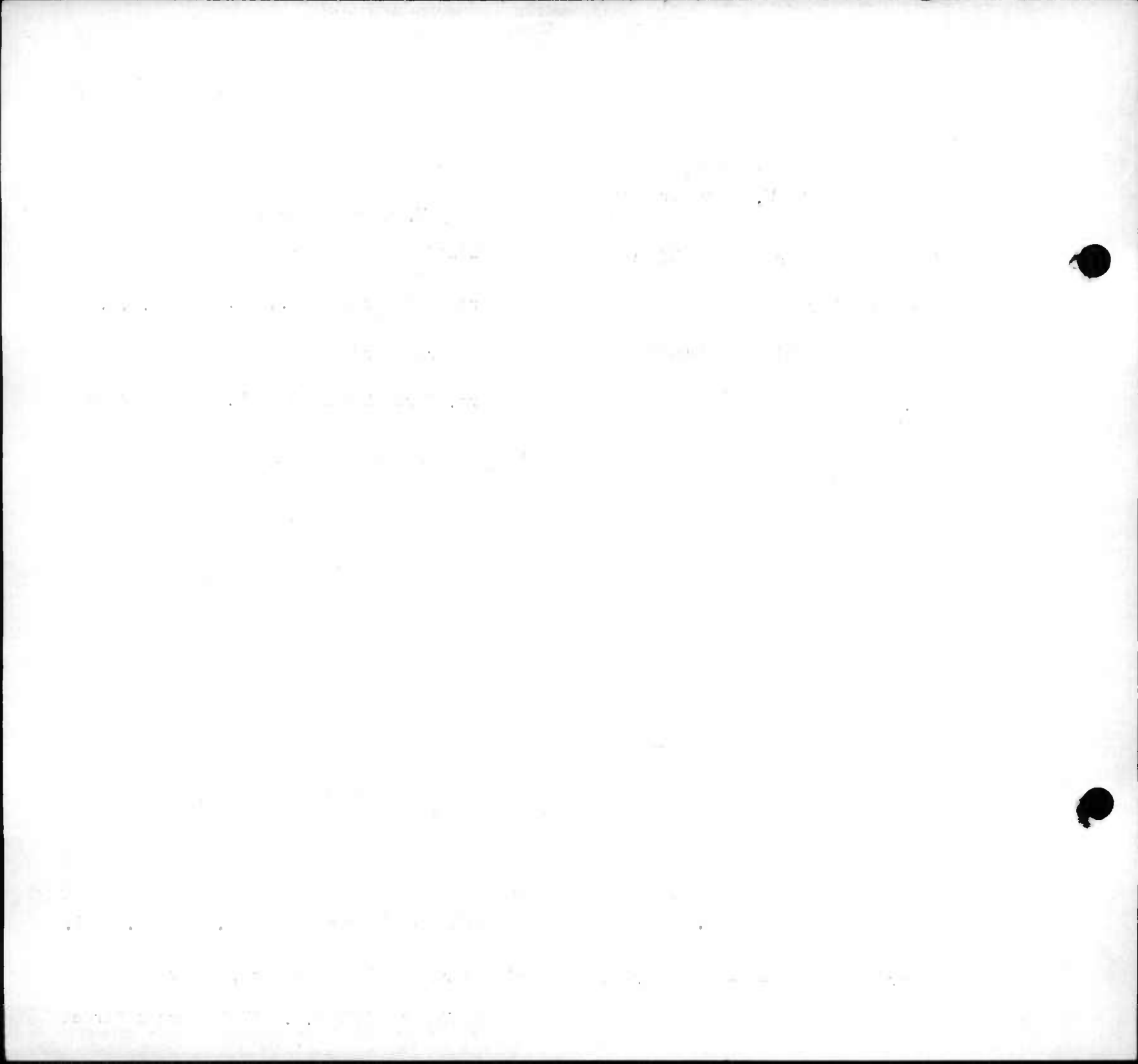
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

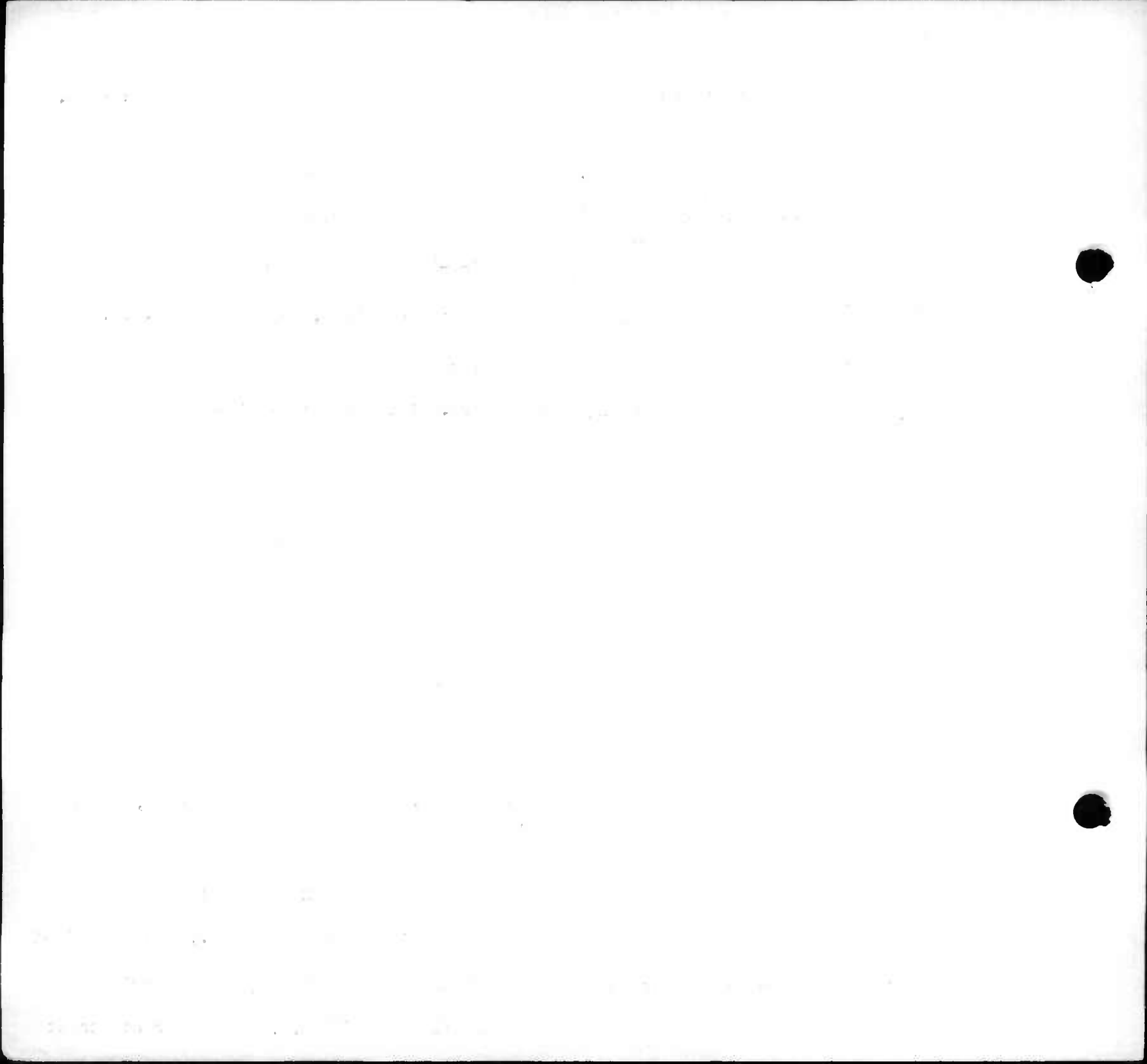
B-630 69 12466 BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. 69 12466	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
GRACE BYRD				Dec 16, 1969 12:05 PM			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
HOUSE IN THE PINES 2525 W. Belvedere Avenue				MARYLAND 1601			
5. SEX 6. RACE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)				8. DATE OF BIRTH 9. AGE (In years lost birthday)			
Female Negro Widowed				7-1-1898 71			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)			
Domestic Work				North Thumberland Co., Va.			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY?			
				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Daniel Blackwell				Sarah Jordan			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No.						Mrs. Sarah Lyles 1003 W. 42nd Street	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II				(A) DUE TO		6/25/69	
ANTECEDENT CAUSES				(B) DUE TO		20 yr.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO		20 yr.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from June 28, 1969 to Dec 16, 1969, that (I) (we) last saw the deceased alive on Dec 12, 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Lester N. Kolman				12/16/69			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
LESTER N. KOLMAN				6821 Reisterstown Rd. Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		12-19-69		Arbutus memorial Park		Baltimore, Maryland	
25A. DATE RECEIVED BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
Dec 17 1969		Robert E. Taylor, Jr.		MORTON & DYETT F.H.		1701 Laurens Street	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

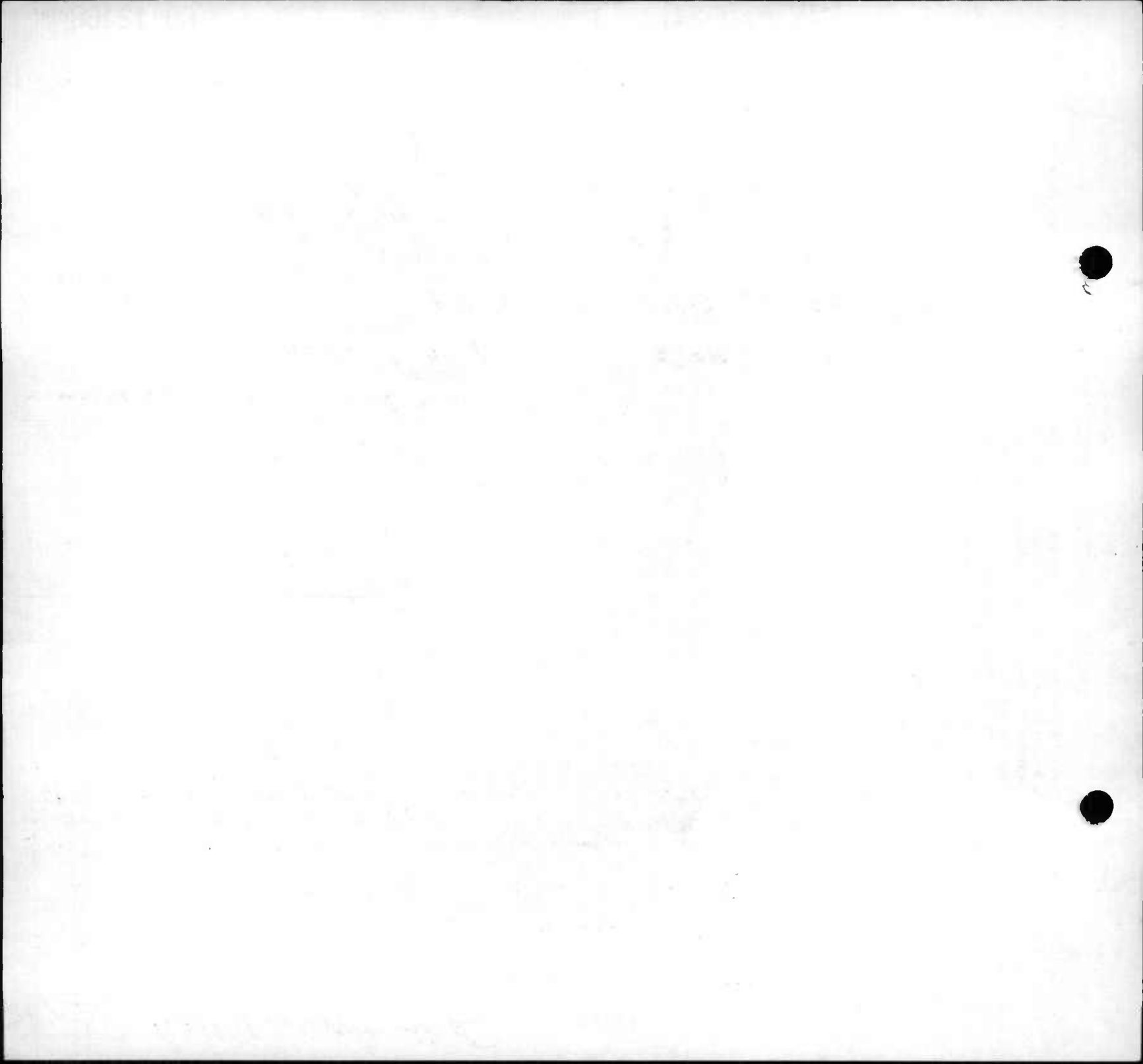
A-535		69 12467		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12467	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Lucius Anthony					
				2. DATE AND HOUR OF DEATH 12/15/69 9:55 p. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1604					
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division Street Baltimore, Maryland 21217				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER 1816 Harlem Avenue					
5. SEX Male	6. RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-5-08	9. AGE (In years last birthday) 61	11. BIRTHPLACE (State or foreign country) South Carolina, Sumpter		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed				10B. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME Felix Anthony				14. MOTHER'S MAIDEN NAME Sarah Smith					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO. 215-07-2071		17. INFORMANT Mrs. Lizzie Anthony- Wife		ADDRESS SAME	
18. 340X CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE Multiple Sclerosis DUE TO, OR AS A CONSEQUENCE OF:				12-2-69	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Pulmonary Congestion DUE TO, OR AS A CONSEQUENCE OF:				12-15-69	
				(C) Dehydration					
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from December 7, 1969 to December 15, 1969 that (I) (we) last saw the deceased alive on December 15, 1969 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Raymundo R. Corpuz, M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED 12/16/69	
23C. PHYSICIAN'S NAME (Type) Raymundo R. Corpuz, M.D.				23D. ADDRESS 1514 Division Street Balto., Maryland 21217					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-20-69		24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969				25B. NAME OF REGISTRAR John E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTON & YETT F.H. ADDRESS 1701 Laurens Street			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
Y-625		69 12468		69 12468	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) ELMER YORKMAN			2. DATE AND HOUR OF DEATH 12/15/69 10 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD. B. COUNTY 2552		
FULL NAME OF HOSPITAL OR INSTITUTION 00316 BRIDGEVIEW RD			C. CITY OR TOWN BALTO.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 316 BRIDGEVIEW		
5. SEX M	6. RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/12/07	9. AGE (In years last birthday) 62	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRESSER		10B. KIND OF BUSINESS OR INDUSTRY SPARKLE CLEANERS		11. BIRTHPLACE (State or foreign country) MD.	
13. FATHER'S NAME ALPHONSO CHASE			14. MOTHER'S MAIDEN NAME CORA YORKMAN		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-01-1496		17. INFORMANT ANNA YORKMAN	
				ADDRESS 316 BRIDGEVIEW RD	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CARCINOMA of the LUNG			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11-11-69 to DEC 5-1969 , that (I) (we) last saw the deceased alive on DEC 5-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. Medical Examiner's Office Consulted					
23A. SIGNATURE Jose V. Iglesias M.D.			Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12-17-69
23C. PHYSICIAN'S NAME (Type) Jose V. Iglesias M.D.			23D. ADDRESS South Baltimore Gen. Hosp.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/19/69		24C. NAME OF CEMETERY OR CREMATORY MT. Auburn Cem	
				24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Joseph E. Taylor, M.D.		25C. FUNERAL DIRECTOR Joseph E. Taylor, M.D.	
				ADDRESS 1304 N. Central Ave	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12469	
BIRTH NO. R-263		69 12469		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) CECELIA B. RICHARDSON			2. DATE AND HOUR OF DEATH 12/15/69 9 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 831 N. FREMONT AVE			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MD B. COUNTY 1703 C. CITY OR TOWN BALTO. D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 831 N. FREMONT AVE		
5. SEX F	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-86	9. AGE (In years last birthday) 83	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC			10B. KIND OF BUSINESS OR INDUSTRY VA.		11. BIRTHPLACE (State or foreign country) VA.
12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME BURTON		
14. MOTHER'S MAIDEN NAME AGNES			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.			17. INFORMANT GENEVA WARD ADDRESS 4307 MIAMI PLACE		
CAUSE OF DEATH					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 1. IMMEDIATE CAUSE Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF: 2. ANTECEDENT CAUSES Atherosclerotic Heart Disease DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (B) _____ (C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 4, 1966 to Feb. 10, 1966 that (I) (we) lost saw the deceased alive on Feb. 10, 1966 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Archie Robinson, Jr. M.D.				23B. DATE SIGNED 12-17-69	
23C. PHYSICIAN'S NAME (Type) ARCHIE ROBINSON, JR. M.D.				23D. ADDRESS 803 N. FREMONT AVE, BALTO. MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12/19/69		24C. NAME OF CEMETERY OR CREMATORY CARVER MEM. PK	
24D. LOCATION (City, town, or county) (State) LAUREL MD		25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969			
25B. NAME OF REGISTRAR Joseph E. Lock		25C. FUNERAL DIRECTOR Joseph E. Lock ADDRESS 13047 Central Ave			

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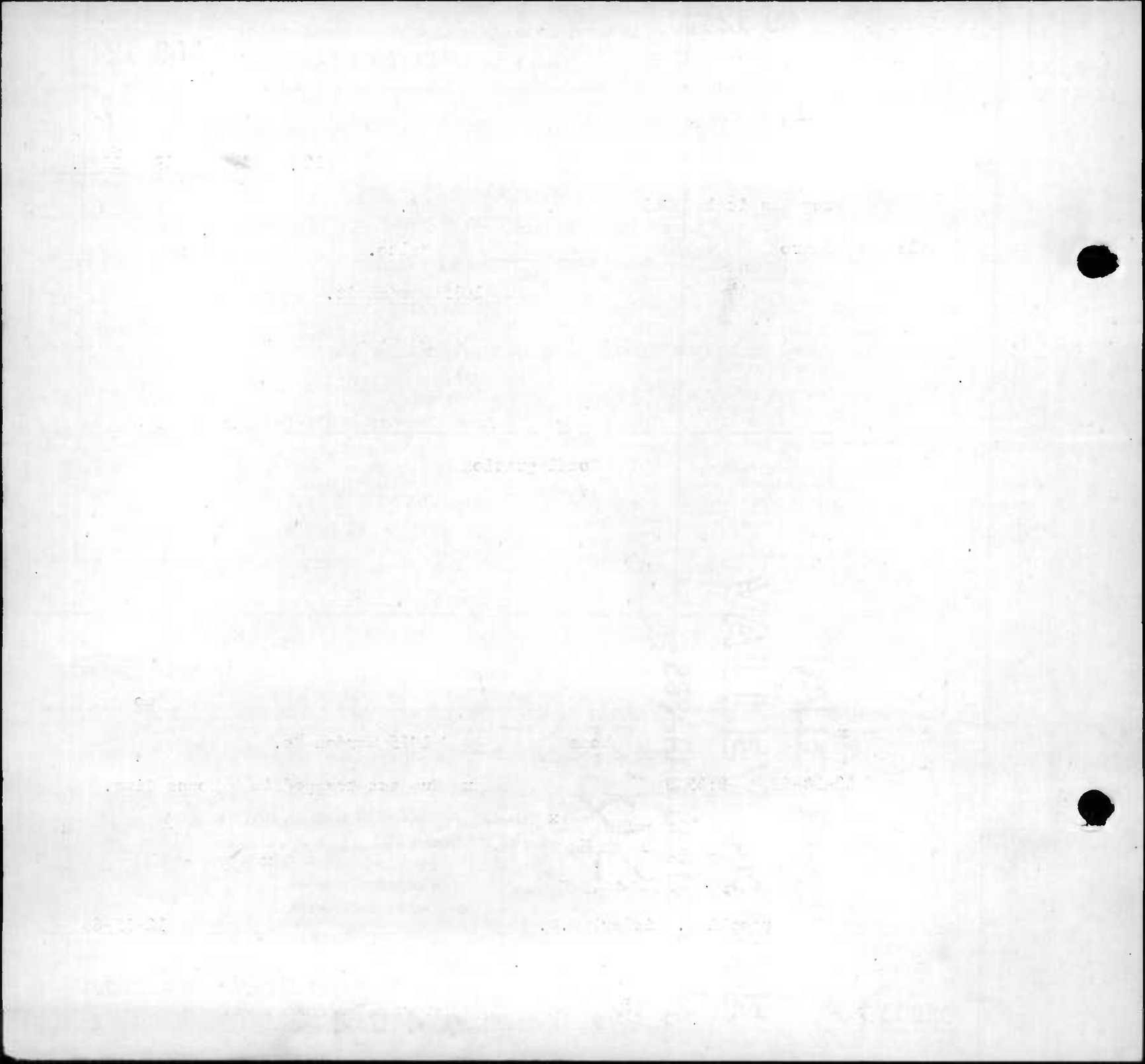
F-656 69 12470 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 69 12470

BIRTH NO. 65 12232 REG. NO.

1. NAME OF DECEASED (Type or Print) W Raymond Farmer, 3rd		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Mercy Hospital (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 14 69 11 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY 10 01	
9. DATE OF BIRTH 5-15-65		10. AGE (In years lost birth day) 4	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Raymond W. Farmer, Jr.		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
15. MOTHER'S MAIDEN NAME Marian Warren		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS Avon Chambers 1034 McAleer Court 21202	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Conflagration		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
		(B) DUE TO, OR AS A CONSEQUENCE OF:	
		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) no			
22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? 1015 Warden St. 1001			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) 12-14-69 9:45 P.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22F. HOW DID INJURY OCCUR? Subject trapped in a house fire.			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Russell S. Fisher, M.D. M.D. EXAMINER'S NAME (Type) DATE SIGNED 12-15-69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-18-69	
24C. NAME OF CEMETERY or CREMATORY Mt. Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A.A. Co., Maryland	
25A. DATE RECEIVED BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.	
25C. FUNERAL DIRECTOR Marshall W. Jones, Jr.		25D. DATE 12-15-69	

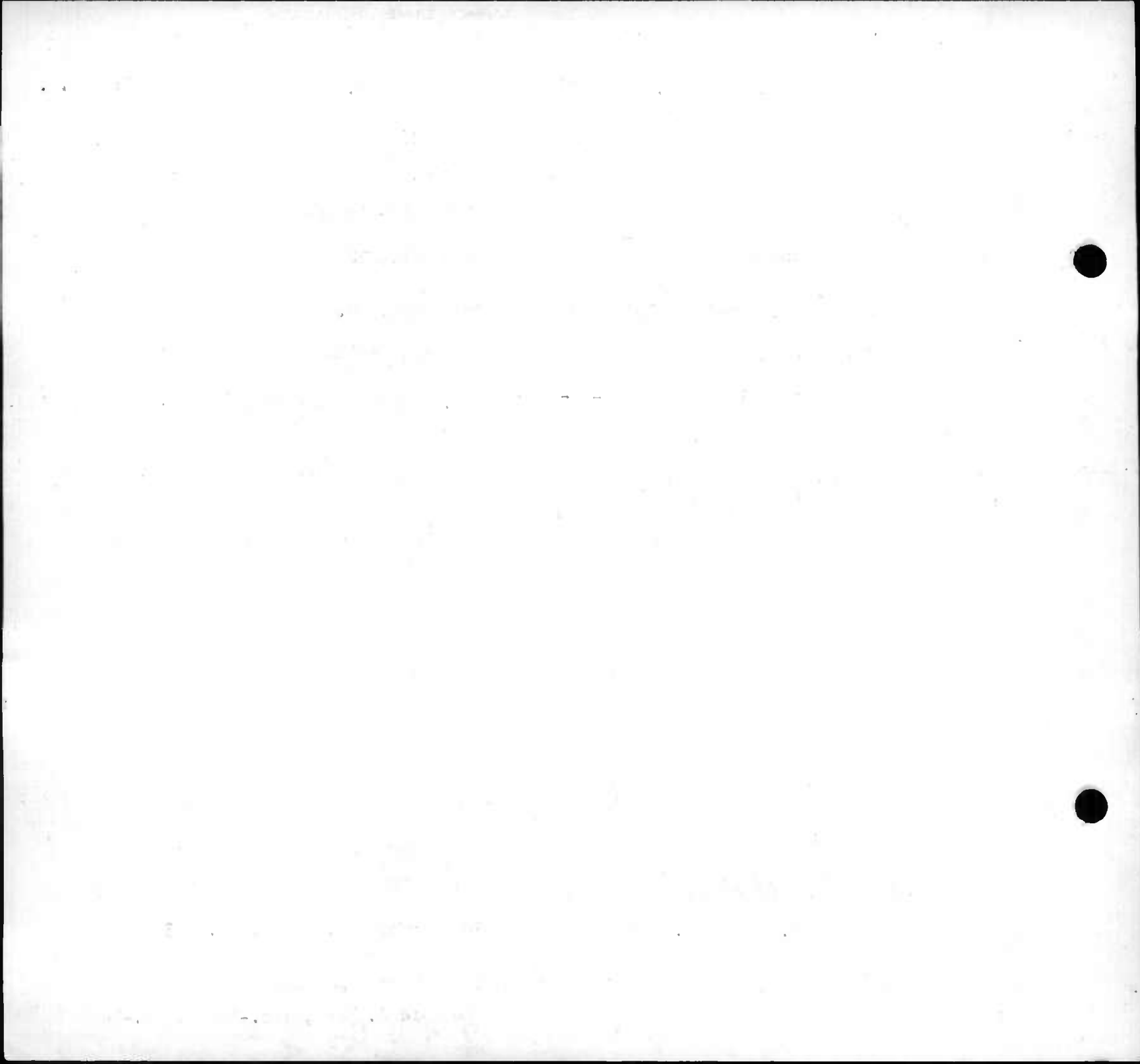
VS 151-REV. 1/1/68



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

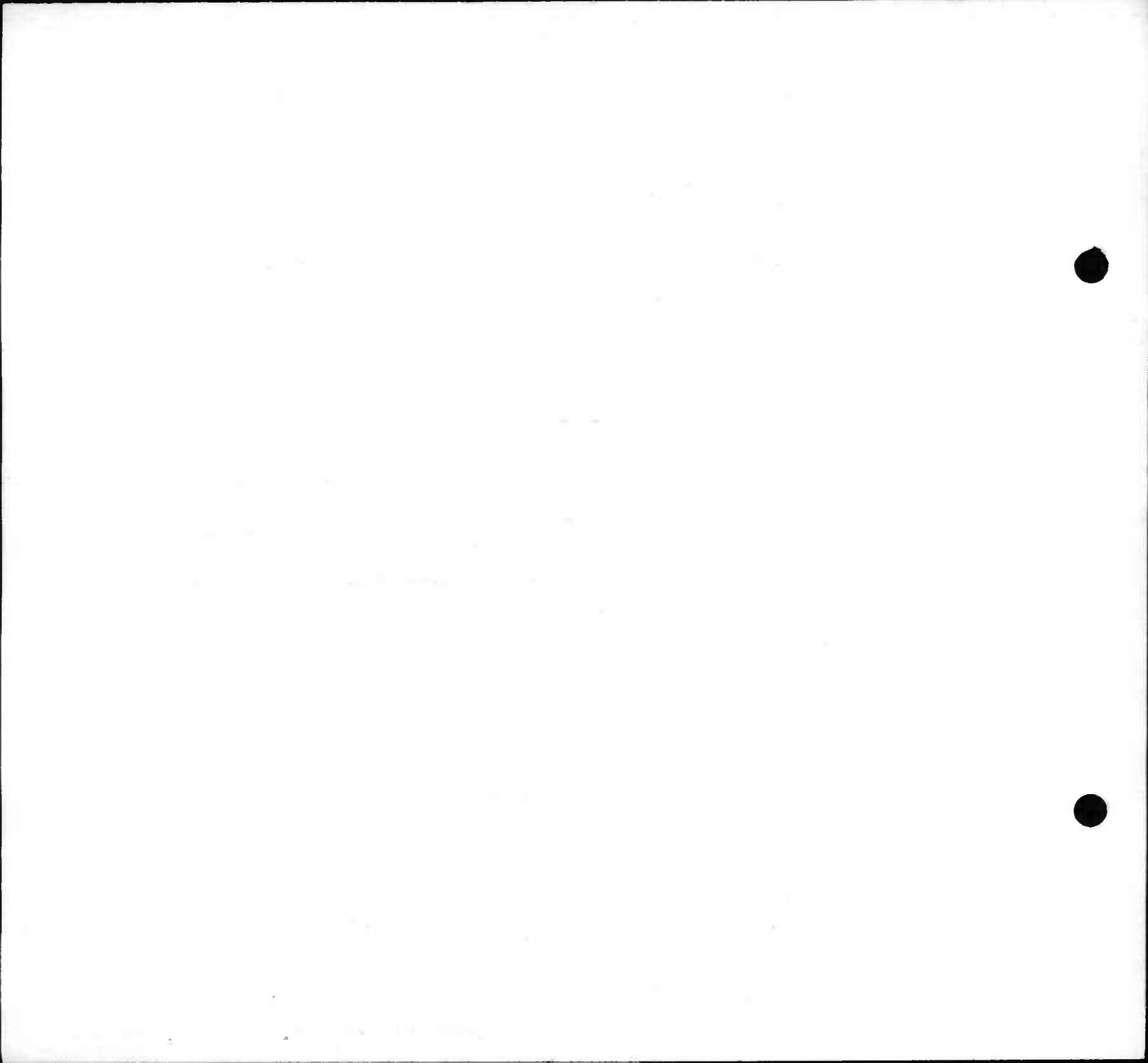
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12471	
BIRTH NO. M-423		69 12471	
1. NAME OF DECEASED (Type or Print) FRANCIS L. MALSTROM		2. DATE AND HOUR OF DEATH Dec. 15, 1969 1:30 A.M. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 3100 White Avenue		4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE Maryland B. COUNTY 2744 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3100 White Avenue	
5. SEX male	6. RACE caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 22, 1892
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10B. KIND OF BUSINESS OR INDUSTRY Clothing	9. AGE (In years last birthday) 77 If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Malstrom		14. MOTHER'S MAIDEN NAME Mary Meehan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war and dates of service) Yes WWI		16. SOCIAL SECURITY NO. 218-09-9878	
17. INFORMANT Mrs. Margaret Malstrom, 3100 White Ave, Balto.		ADDRESS	
18. 170.3 I CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Carcinomatous (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of Ribs (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months 1 yr.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Sept. 1969 to Dec 15 1969, that (I) (we) last saw the deceased alive on Dec 14 , 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Harold H Burns M.D.		23B. DATE SIGNED 12-15-69	
23C. PHYSICIAN'S NAME (Type) Dr. Harold H. Burns		23D. ADDRESS 8106 Harford Rd, Balto, Md. - 34	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/69	
24C. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Leonard J. Ruck, Inc.-Balto, Md.-14	
25C. FUNERAL DIRECTOR		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

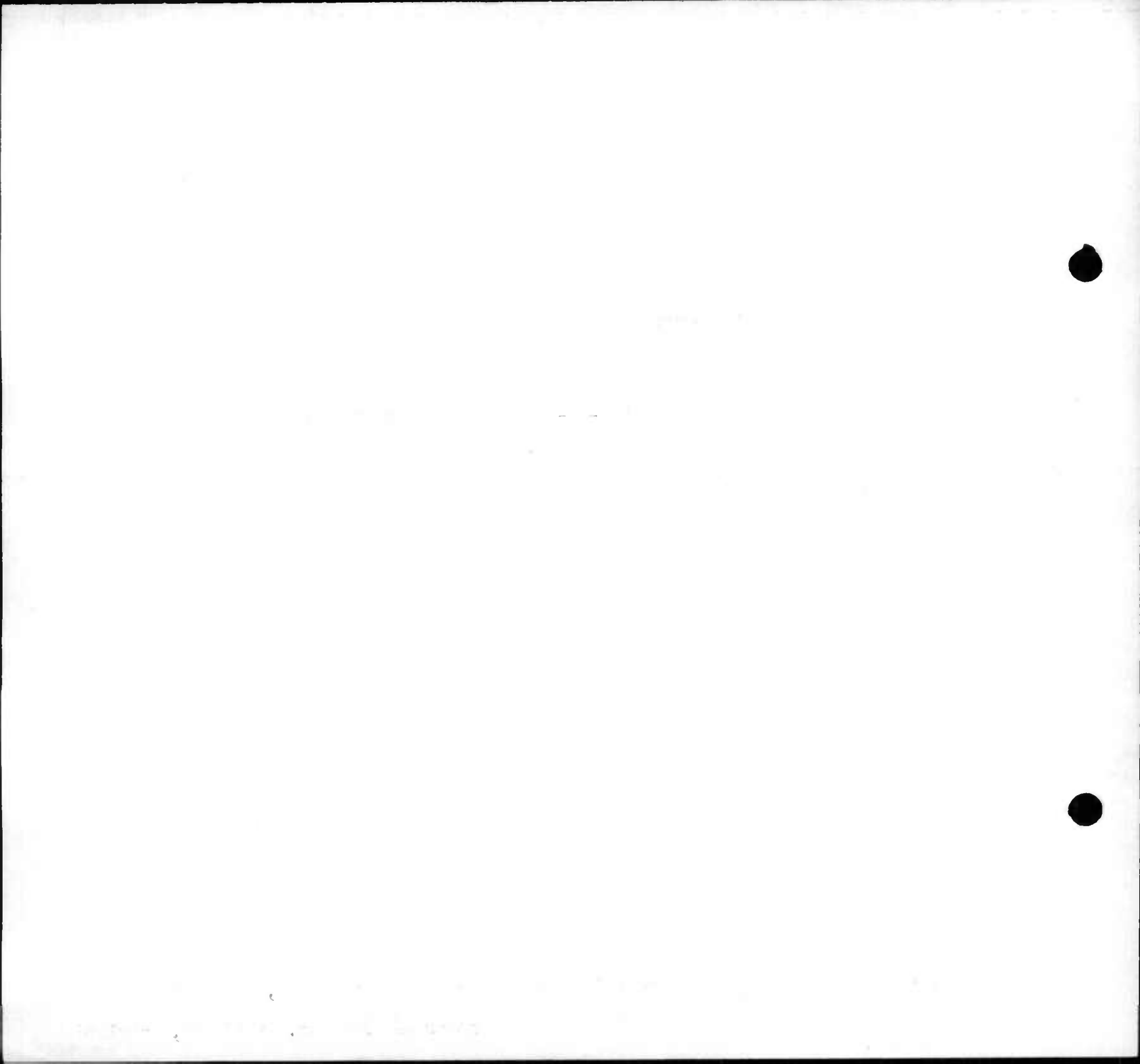
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p>B-650 69 12472 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12472</p>	
<p>BIRTH NO.</p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>1. NAME OF DECEASED (Type or Print) <u>Green Henry H.</u></p>		<p><u>Dec 14/69</u> <u>9 20 AM</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)</p> <p><u>University of Maryland Hosp.</u> <u>Baltimore, Md, 21201</u></p>		<p>A. STATE <u>Md.</u> B. COUNTY <u>Charles</u></p>	
<p>5. SEX <u>male</u> 6. RACE <u>white</u></p>		<p>C. CITY OR TOWN <u>BENEDICT</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>5/29/13</u></p>		<p>9. AGE (In years last birthday) <u>56</u></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><u>Engineer</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>Md. State Roads Comm.</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>Md.</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u></p>	
<p>13. FATHER'S NAME <u>Henry G Green</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Honora Flynn</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p><u>Yes</u> <u>WWII</u></p>		<p>16. SOCIAL SECURITY NO. <u>213-20-5429</u></p>	
<p>17. INFORMANT <u>Mrs Helen Delaney</u></p>		<p>ADDRESS <u>5523 Sefton Ave</u></p>	
<p>18. CAUSE OF DEATH</p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><u>VENTRICULAR FIBRILLATION</u></p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><u>CHRONIC Congestive Heart Failure</u></p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> <p><u>LT. PYO-PNEUMOTHORAX = Hypoxia</u></p>		<p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>19A. DATE OF OPERATION <u>12/13/69</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <u>Yes</u></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u></p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>12/13/69</u> 19 to <u>12/14/69</u> 19</p> <p>that (I) (we) last saw the deceased alive on <u>12/14/69</u> 19 and that in (my) (our) opinion death occurred on the date</p> <p>and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>M. H. Gonzalez M.D.</u></p>		<p>23B. DATE SIGNED <u>Dec 14/69</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>M. H. Gonzalez M.D.</u></p>		<p>23D. ADDRESS <u>University of Maryland Hosp.</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>24B. DATE <u>12/18/69</u></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>DEC 17 1969</u></p>		<p>25B. NAME OF REGISTRAR <u>Donald J. Rock</u></p>	
<p>25C. FUNERAL DIRECTOR <u>Donald J. Rock Inc.</u></p>		<p>ADDRESS <u>Baltimore, Maryland</u></p>	



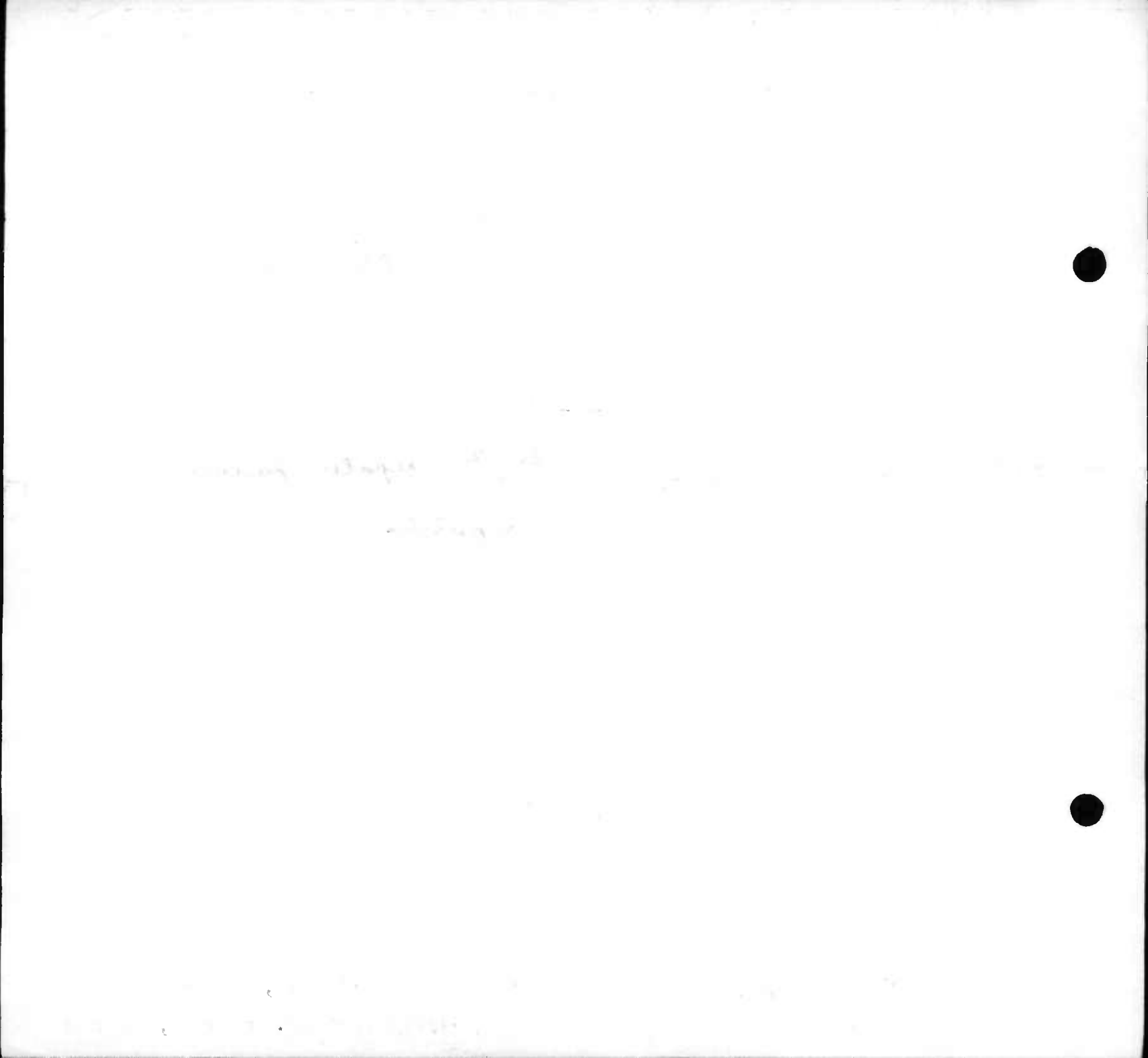
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		69 12473		REG. NO.		69 12473	
1. NAME OF DECEASED (Type or Print) KECK, PHILLIP J.				2. DATE AND HOUR OF DEATH DEC - 15 - 69 8:00 A M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Union Memorial Hospital 44				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2207 Maryland Ave					
5. SEX M	6. RACE W/M	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-25-91	9. AGE (In years last birthday) 77	10. UNDER 1 Yr. Months: Days		11. UNDER 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME Phillip Keck				14. MOTHER'S MAIDEN NAME Bierlie Margaret					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 179-14-1762A		17. INFORMANT Mrs Katherine Keck		ADDRESS Same	
18. 450X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pulmonary embolism ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pulmonary embolism (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 11/14 19 69 to 12/15 19 69 that (I) (we) last saw the deceased alive on 12/15 19 69 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
23A. SIGNATURE T. J. T. J.				23B. DATE SIGNED 12-15-69					
23C. PHYSICIAN'S NAME (Type) TAGAWA				23D. ADDRESS M.O.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/69		24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Galt		25C. FUNERAL DIRECTOR Leonard J. Ruck Inc.		ADDRESS Baltimore, Maryland			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12474	
1-236 69 12474		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) AMADO B DESTREZA Jr	
2. DATE AND HOUR OF DEATH DECEMBER 15, 1969 9:00 A.M.		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1202		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL	
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 3037 BARCLAY ST		5. SEX MALE 6. RACE FILIPINO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 1942 APRIL 17, 1942 9. AGE (In years last birthday) 27		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CLERICAL (FRAME MAKER)	
10B. KIND OF BUSINESS OR INDUSTRY BALTO. C & P TELEPHONE		11. BIRTHPLACE (State or foreign country) PHILIPPINES	
12. CITIZEN OF WHAT COUNTRY? AMERICAN		13. FATHER'S NAME AMADO DESTREZA, SR.	
14. MOTHER'S MAIDEN NAME PURIFICATION BAUTISTA		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES	
16. SOCIAL SECURITY NO. 549-64-6696		17. INFORMANT MARY DESTREZA JR. BALTO., MD. ADDRESS 3037 BARCLAY ST.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Renal failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Hepatitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 0.4.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from NOVEMBER 28 1969 to DECEMBER 15 1969 that (I) (we) last saw the deceased alive on DECEMBER 15 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Yu. Sui Lit M.D. DEGREE		23B. DATE SIGNED 12-15-69	
23C. PHYSICIAN'S NAME (Type) YU. SUI LIT		23D. ADDRESS MD UNION MEMORIAL HOSP., BALTO., MD.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/69	
24C. NAME of CEMETERY or CREMATORY Baltimore National		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. J. J. J.	
25C. FUNERAL DIRECTOR Leonard J. Buck Inc.		ADDRESS Baltimore, Maryland	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-416		69 12475		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		69 12475	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) ELIZABETH CALVERT				2. DATE AND HOUR OF DEATH 12/14/69 1:23 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 SINAI HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD B. COUNTY BALTIMORE 2740			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 SINAI HOSPITAL				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 6120 GREENSPRING AVE			
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/17/02	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Roger S Whiteford				14. MOTHER'S MAIDEN NAME Mammie Kilgore			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Mr Robert N Calvert Jr 6120 Green Spring Ave	
18. 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE PULM. EDEMA ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ACUTE MYOCARDIAL INFARCTION ASCVD + HYPERTENSION				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). PNEUMONIA							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from DEC. 6 1969 to DEC 14 1969 that (1) we last saw the deceased alive on DEC. 14 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Victor Borden M.D.				23B. DATE SIGNED 12/14/69		23C. PHYSICIAN'S NAME (Type) VICTOR BORDEN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/17/69		24C. NAME of CEMETERY or CREMATORY Lorraine Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Leonard J Ruck Inc.		ADDRESS Baltimore, Maryland	

10/15/68

11/15/68

F W

Acute Hypertension
Acute Myocardial Infarction
Acute Pulmonary Edema

11/15/68

202

11/15/68

11/15/68

11/15/68

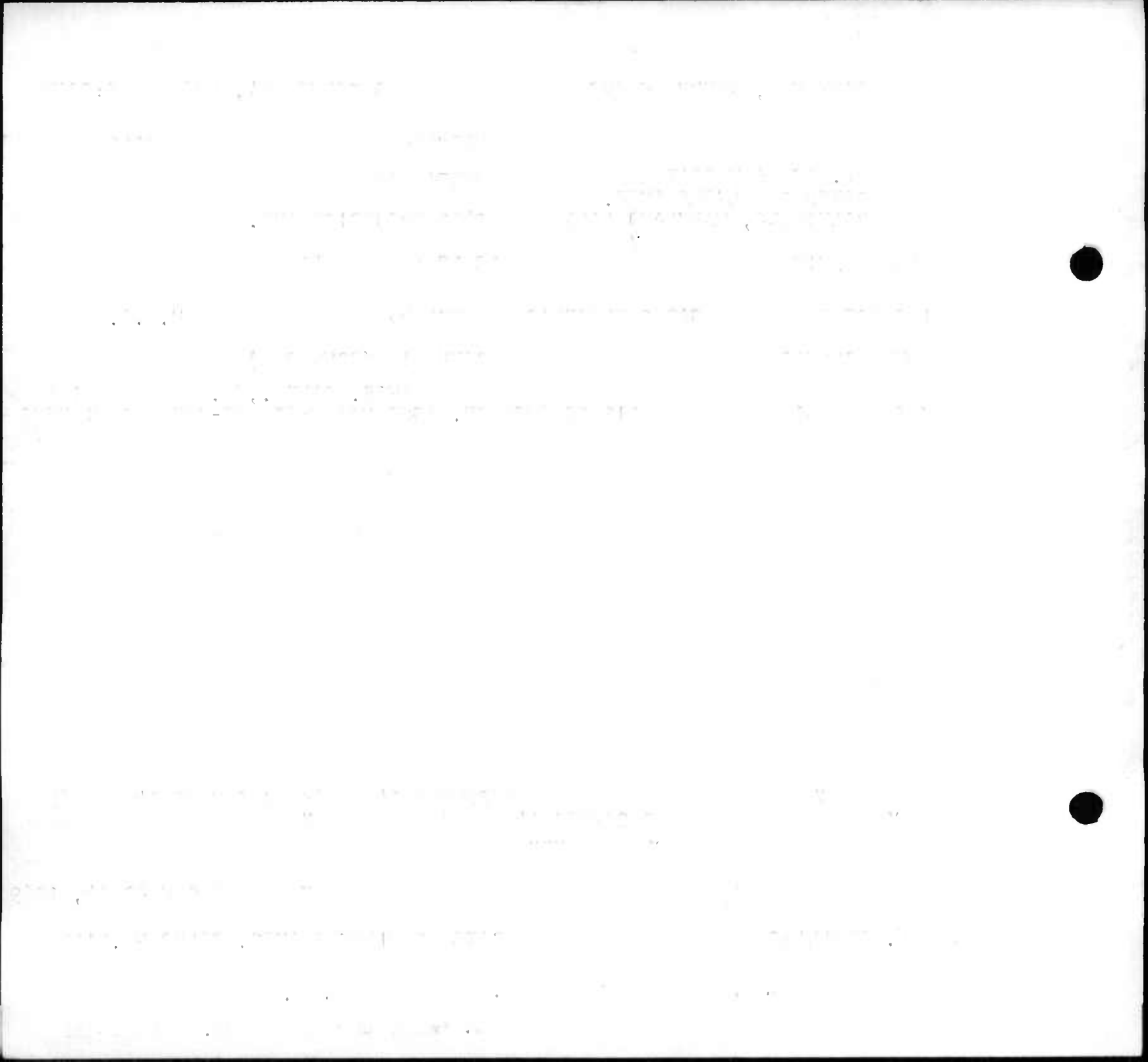
Victor Berben M.D.
Victor Berben M.D.

MEDICAL EXAMINER RELEASE BODY
DR. SPITZ

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-510		69 12476		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12476	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) SCHNEPFE, ARTHUR GEORGE			
2. DATE AND HOUR OF DEATH DECEMBER 14, 1969 5:55AM M.							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND 21229 2008 B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 3422 FREDERICK AVE.			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 20 88	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR		10B. KIND OF BUSINESS OR INDUSTRY GAS & ELECTRIC		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SCHNEPFE				14. MOTHER'S MAIDEN NAME CATHERINE (SCHNAGER)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW1		16. SOCIAL SECURITY NO. 212 05 6059		17. INFORMANT AVES. BALTO., MD. 21229 ST. AGNES HOSP RECORDS-CATON & WILKENS		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 12-14-69 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nately medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (X) (this hospital) attended the deceased from DECEMBER 14 19 69 to DECEMBER 14 19 69 that (X) (we) last saw the deceased alive on DECEMBER 14 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. 23A. SIGNATURE M. Cabiling 23B. DATE SIGNED DECEMBER 14, 1969 23C. PHYSICIAN'S NAME (Type) M. CABILING 23D. ADDRESS CATON & WILKENS AVES. BALTO MD. 21229 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE Dec. 17, 1969 24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cem. 24D. LOCATION Balto. Md. 25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969 25B. NAME OF REGISTRAR J. H. Schab 25C. FUNERAL DIRECTOR Schwab 5151 Balto. National Pike ADDRESS							



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. X	69 12477
BIRTH NO. 1. NAME OF DECEASED (Type or Print) HERMAN GREGORY VOELKER		2. DATE AND HOUR OF DEATH 12-12-69 2:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD HARFORD GARDENS CONVALESCENT HOME FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 4700 Harford Rd. Baltimore, Md 21214		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Md. B. COUNTY 53-00 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 534 Walker Ave. Apt. F			
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/28/1900	9. AGE (in years last birthday) 69
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired V. Pres of Sales		10B. KIND OF BUSINESS OR INDUSTRY Parker Metal & Dec/Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Henry Voelker		14. MOTHER'S MAIDEN NAME Rose Schultz			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 215-07-D156		17. INFORMANT Mrs. Ellen Voelker ADDRESS 534 Walker St. Apt. F Balto.	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 412.41 ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. </div> <div style="width: 50%;"> Eerebral Sclerosis (severe) (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) </div> </div> <div style="text-align: right; margin-top: 10px;"> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24+5. 57+5. </div>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov. 10 19 67 to Dec. 10 19 69 that (I) (we) last saw the deceased alive on Dec. 10 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wm. H. Kammer Jr.				23B. DATE SIGNED 13 Dec. 69	
23C. PHYSICIAN'S NAME (Type) Dr. William H. Kammer				23D. ADDRESS 6011 York Rd. Balto., Md. 21212	
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 12/15/69		24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cemetery	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Mitchell-Wiedefeld Home	
25D. ADDRESS 6500 York Rd. Balto., Md. 21212					

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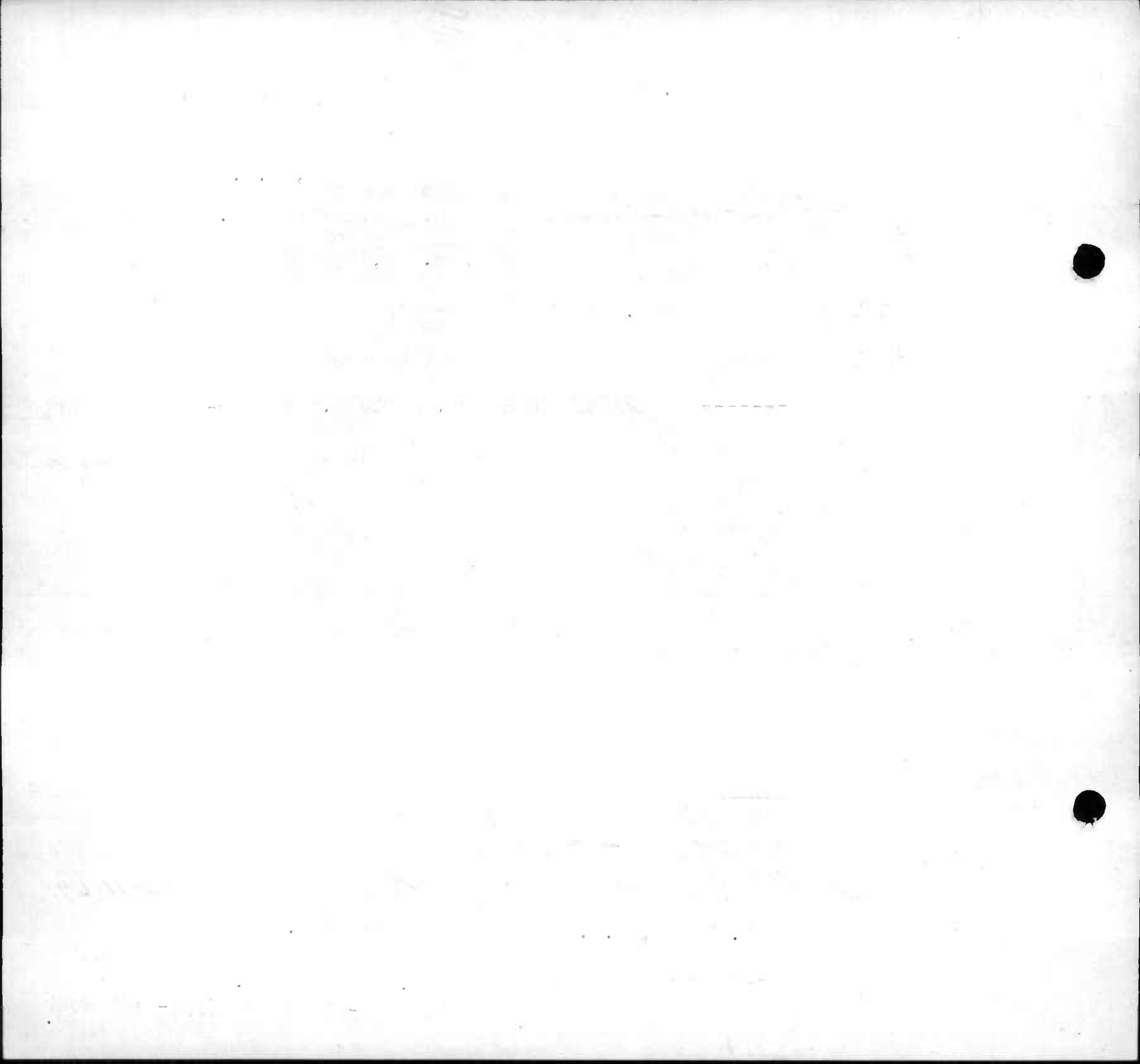
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FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="font-size: 2em; font-family: cursive;">S-512</div> <div style="font-size: 2em; font-family: cursive;">69 12478</div>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <div style="font-size: 2em; font-family: cursive;">69 12478</div>
BIRTH NO. <div style="font-size: 2em; font-family: cursive;">5-512</div>		2. DATE AND HOUR OF DEATH <div style="font-size: 1.5em; font-family: cursive;">December 10th, 69</div>		
1. NAME OF DECEASED (Type or Print) <div style="font-size: 1.2em; font-family: cursive;">Thomas W. Sampson</div>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <div style="font-size: 1.2em; font-family: cursive;">Maryland</div> B. COUNTY <div style="font-size: 1.2em; font-family: cursive;">Balto. Co.</div>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 1.5em; font-family: cursive;">90 Pleasant Manor Nursing Home 4615 Park Heights Avenue</div>		C. CITY OR TOWN <div style="font-size: 1.2em; font-family: cursive;">Rodgers Forge, B.C.</div> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX <div style="font-size: 1.2em; font-family: cursive;">Male</div> 6. RACE <div style="font-size: 1.2em; font-family: cursive;">White</div>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em; font-family: cursive;">Expiditor</div>		11. BIRTHPLACE (State or foreign country) <div style="font-size: 1.2em; font-family: cursive;">Maryland</div>		
13. FATHER'S NAME <div style="font-size: 1.2em; font-family: cursive;">William Sampson</div>		14. MOTHER'S MAIDEN NAME <div style="font-size: 1.2em; font-family: cursive;">Emily Rauch</div>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <div style="font-size: 1.2em; font-family: cursive;">no</div>		16. SOCIAL SECURITY NO. <div style="font-size: 1.2em; font-family: cursive;">218-10-8013 A</div>		
17. INFORMANT <div style="font-size: 1.2em; font-family: cursive;">Mrs. Marie H. Sampson-100 C Dumbarto</div>		ADDRESS <div style="font-size: 1.2em; font-family: cursive;">100 C Dumbarto</div>		
18. <div style="font-size: 1.5em; font-family: cursive;">162-1</div> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <div style="font-size: 1.2em; font-family: cursive;">Metastatic Carcinoma</div>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <div style="font-size: 1.2em; font-family: cursive;">Carcinoma Lung</div>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="font-size: 1.2em; font-family: cursive;">Dehydration</div>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.2em; font-family: cursive;">6 months</div>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <div style="font-size: 1.2em; font-family: cursive;">Dehydration</div>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="font-size: 1.2em; font-family: cursive;">1 week</div>		
19A. DATE OF OPERATION <div style="font-size: 1.2em; font-family: cursive;">0</div>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <div style="font-size: 1.2em; font-family: cursive;">-</div>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <div style="font-size: 1.2em; font-family: cursive;">-</div>		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <div style="font-size: 1.2em; font-family: cursive;">-</div>		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <div style="font-size: 1.2em; font-family: cursive;">-</div>		21F. HOW DID INJURY OCCUR? <div style="font-size: 1.2em; font-family: cursive;">-</div>		
22. I certify that (I) (this hospital) attended the deceased from <div style="font-size: 1.2em; font-family: cursive;">12-5</div> 1969 to <div style="font-size: 1.2em; font-family: cursive;">12-10</div> 1969, that (I) (we) last saw the deceased alive on <div style="font-size: 1.2em; font-family: cursive;">12-9</div> 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.				
23A. SIGNATURE <div style="font-size: 1.5em; font-family: cursive;">Frank G. Kuehn</div>		23B. DATE SIGNED <div style="font-size: 1.2em; font-family: cursive;">12-11-69</div>		
23C. PHYSICIAN'S NAME (Type) <div style="font-size: 1.2em; font-family: cursive;">Frank G. Kuehn, M.D.</div>		23D. ADDRESS <div style="font-size: 1.2em; font-family: cursive;">Med Arts Bldg.</div>		
24A. BURIAL CREMATION, REMOVAL (Specify) <div style="font-size: 1.2em; font-family: cursive;">Burial</div>		24B. DATE <div style="font-size: 1.2em; font-family: cursive;">12/12/69</div>		
24C. NAME OF CEMETERY or CREMATORY <div style="font-size: 1.2em; font-family: cursive;">Holy Redeemer Cem.</div>		24D. LOCATION (City, town, or county) (State) <div style="font-size: 1.2em; font-family: cursive;">Balto.</div>		
25A. DATE REC'D BY HEALTH DEPT. <div style="font-size: 1.2em; font-family: cursive;">DEC 17 1969</div>		25B. NAME OF REGISTRAR <div style="font-size: 1.2em; font-family: cursive;">Robert E. Fisher, Jr.</div>		
25C. FUNERAL DIRECTOR <div style="font-size: 1.2em; font-family: cursive;">Wiedefeld Home</div>		ADDRESS <div style="font-size: 1.2em; font-family: cursive;">6500 York Rd. 21212</div>		



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

69 12479

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) H. Robert Kavanaugh Jr.		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 12 13 69 2:35 p.m.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 92 City Jail (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 12 13 69 2:35 p.m.	
6. SEX male		7. RACE white	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 8/19/1951		10. AGE (in years lost birthday) 18	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert H. Kavanaugh Sr.		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2712	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		18. SOCIAL SECURITY NO. 218 58 5569	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) E953X		20. INFORMANT Robert H. Kavanaugh	
21. CAUSE OF DEATH (A) IMMEDIATE CAUSE Hanging DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		22. ADDRESS 102 Gittings Ave.	
23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		26. MEDICAL CERTIFICATION	
27A. DATE OF OPERATION 0		27B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
28A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) jail	
28C. WHERE DID INJURY OCCUR? City Jail		28D. HOW DID INJURY OCCUR? 1003 hanged self	
29. TIME (Month) (Day) (Year) (Hour) (Approx.) 12 13 69 approx. 2:30 p.m.		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
31. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		32. ACTUAL SIGNATURE Werner U. Spitz, M.D.	
33. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		34. DATE SIGNED 12/14/69	
35. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		36. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
37. DEPUTY CHIEF MEDICAL EXAMINER <input type="checkbox"/>		38. REMOVAL (Specify) Burial	
39. DATE 12/16/69		40. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
41. LOCATION (City, town, or county) (State) Frederick Rd. Balto. Md		42. DATE REC'D BY HEALTH DEPT. DEC 17 1969	
43. NAME OF REGISTRAR 2200 F. Taylor, Jr.		44. FUNERAL DIRECTOR Mitchell Wiedefeld Home	
45. ADDRESS 6500 York Rd		46. BALTO. MD. 21212	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-455		69 12480		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12480	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) JACOB BLUMENKRANTZ			
2. DATE AND HOUR OF DEATH 12/17/69 10⁰⁰ A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 42 SINAI HOSPITAL			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER 3905 LABYRINTH ROAD	
5. SEX M	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9 1907	9. AGE (In years last birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Itabbi		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Moshe Blumenkrantz				14. MOTHER'S MAIDEN NAME Chia			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. 216-36-8704		17. INFORMANT ADDRESS Mrs. Esther Blumenkrantz, 3905 Labyrinth Rd.			
18. 599.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Gram negative Sepsis & Shock.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Gram - Pneumonia + U. T. I.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) _____ (C) _____					
MEDICAL CERTIFICATION		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Myocardial Infarction & Thrombosis 3 months					
		19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Sept 23 1969 to Dec 17 1969 that (I) (we) last saw the deceased alive on Dec 17 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Victor Borden M.D.				23B. DATE SIGNED 12/17/69		23C. ADDRESS SINAI HOSPITAL	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 12/19/69		24C. NAME OF CEMETERY or CREMATORY Har Hamuchon		24D. LOCATION (City, town, or county) (State) Baltimore Maryland	
25A. DATE REC'D BY HEALTH DEPT. DEC 17 1969		25B. NAME OF REGISTRAR John A. Kelly, M.D.		25C. FUNERAL DIRECTOR Joseph J. S. 9610 Reisterstown Rd			

Singh Hospital
M W X

FOR ST. AND. N. T. I.
C

When visiting Singh
Hospital, N. T. I.

Physician for the
N. T. I.

Victor Borden M.D.
Singh Hospital
X 10/1/61
C O C
Dec 11 1961

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

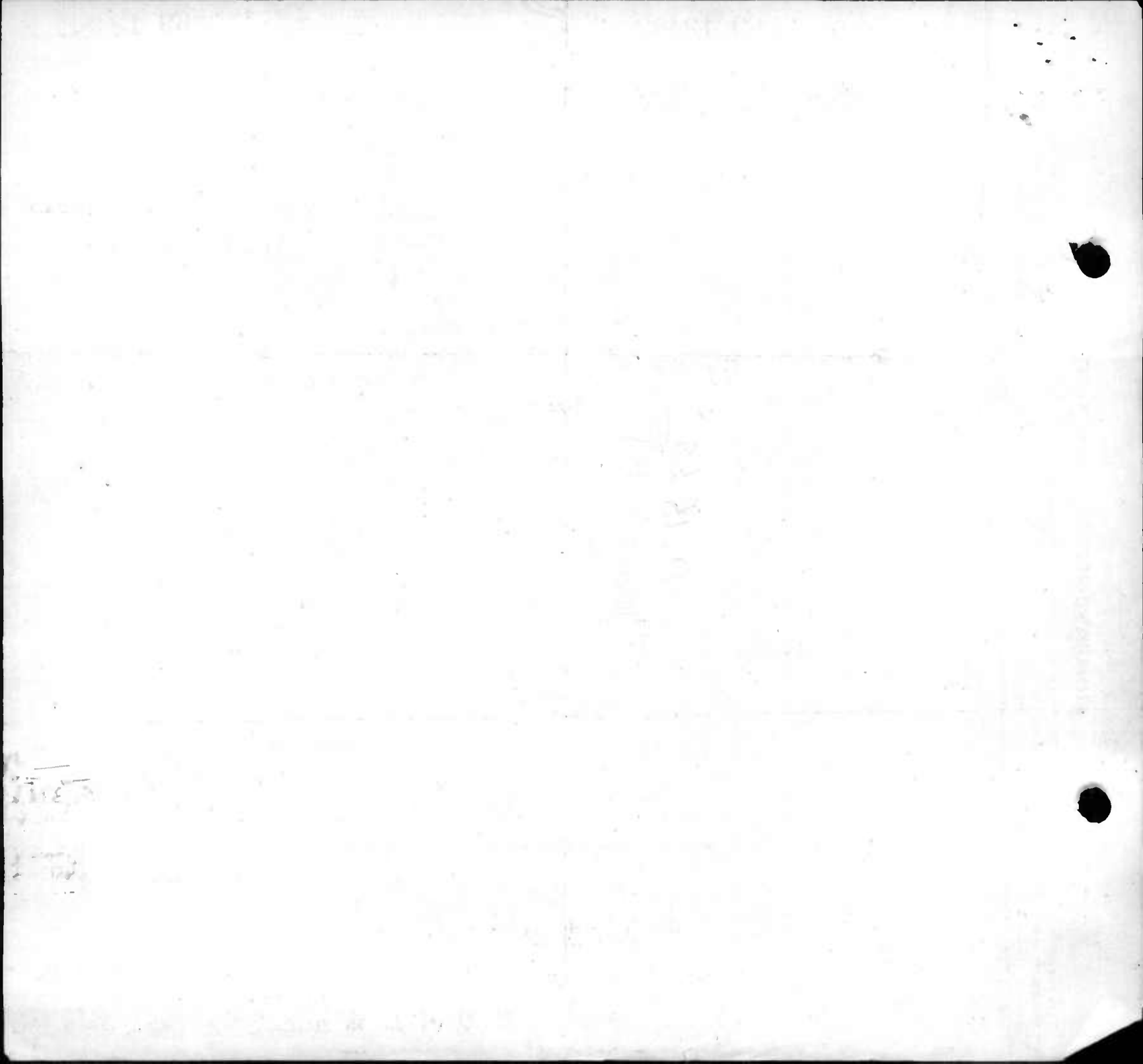
BALTIMORE CITY HEALTH DEPARTMENT		69 12481		CERTIFICATE OF DEATH		REG. NO. 69 12481	
BIRTH NO. C-462				1			
1. NAME OF DECEASED (Type or Print) William Clark				2. DATE AND HOUR OF DEATH 12/9/69 9:20 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Maryland General Hosp.				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MD B. COUNTY 1802			
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/16/1900	
9. AGE (in years last birthday) 69		10. UNDER 1 Yr. Months Days		11. BIRTHPLACE (State or foreign country) Lincoln Memorial Home		12. CITIZEN OF WHAT COUNTRY?	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 436.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osleria, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH CVA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ANTECEDENT CAUSES (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11:28 19 69 to 12/9 19 69 that (I) (we) last saw the deceased alive on 12/9 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE mitchell y...				23B. DATE SIGNED 12/9/69		23C. PHYSICIAN'S NAME (Type)	
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE 12-16-69		24C. NAME of CEMETERY or CREMATOR	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969				25B. NAME OF REGISTRAR Robert E. ...		25C. FUNERAL DIRECTOR MORTUARY SERVICE - BCD	

Address 27 N. Carey

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-500		69 12482		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 69 12482	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <u>LYDIA E. RONEY</u>					
2. DATE AND HOUR OF DEATH <u>12-11-69</u> <u>7:45 A.</u> M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SOUTH BALTIMORE GEN Hospital</u> <u>43</u>					
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>PENNA.</u> B. COUNTY <u>OXFORD</u>				C. CITY OR TOWN <u>OXFORD</u>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>4634 1/2 - 8TH ST. BALD MD 21221</u>				5. SEX <u>F</u>				6. RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>10-4-89</u>				9. AGE (In years last birthday) <u>80</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>FRANKLIN SPIERMAN</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE BAILEY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>179-12-8234</u>				17. INFORMANT ADDRESS <u>DECEASED</u>	
18. <u>145.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>D</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>12-11-69</u> to <u>12-11-69</u> , that (I) (we) last saw the deceased alive on <u>12-11-69</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>Marcelino C. Sonorgon, M.D.</u> DEGREE 23B. DATE SIGNED <u>12-11-69</u> 23C. PHYSICIAN'S NAME (Type) <u>MARCELINO C. SONORGON M.D.</u> DEGREE 23D. ADDRESS <u>5734 F</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>12/14/1969</u> 24B. DATE 24C. NAME OF CEMETERY or CREMATORY <u>FREEMONT</u> 24D. LOCATION (City, town, or county) (State) <u>NOTTINGHAM PA.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1969</u> 25B. NAME OF REGISTRAR <u>Robert E. Fisher, M.D.</u> 25C. FUNERAL DIRECTOR <u>RALPH M. REED</u> ADDRESS <u>RISING SUN, MD.</u>									



C-636 69 12483

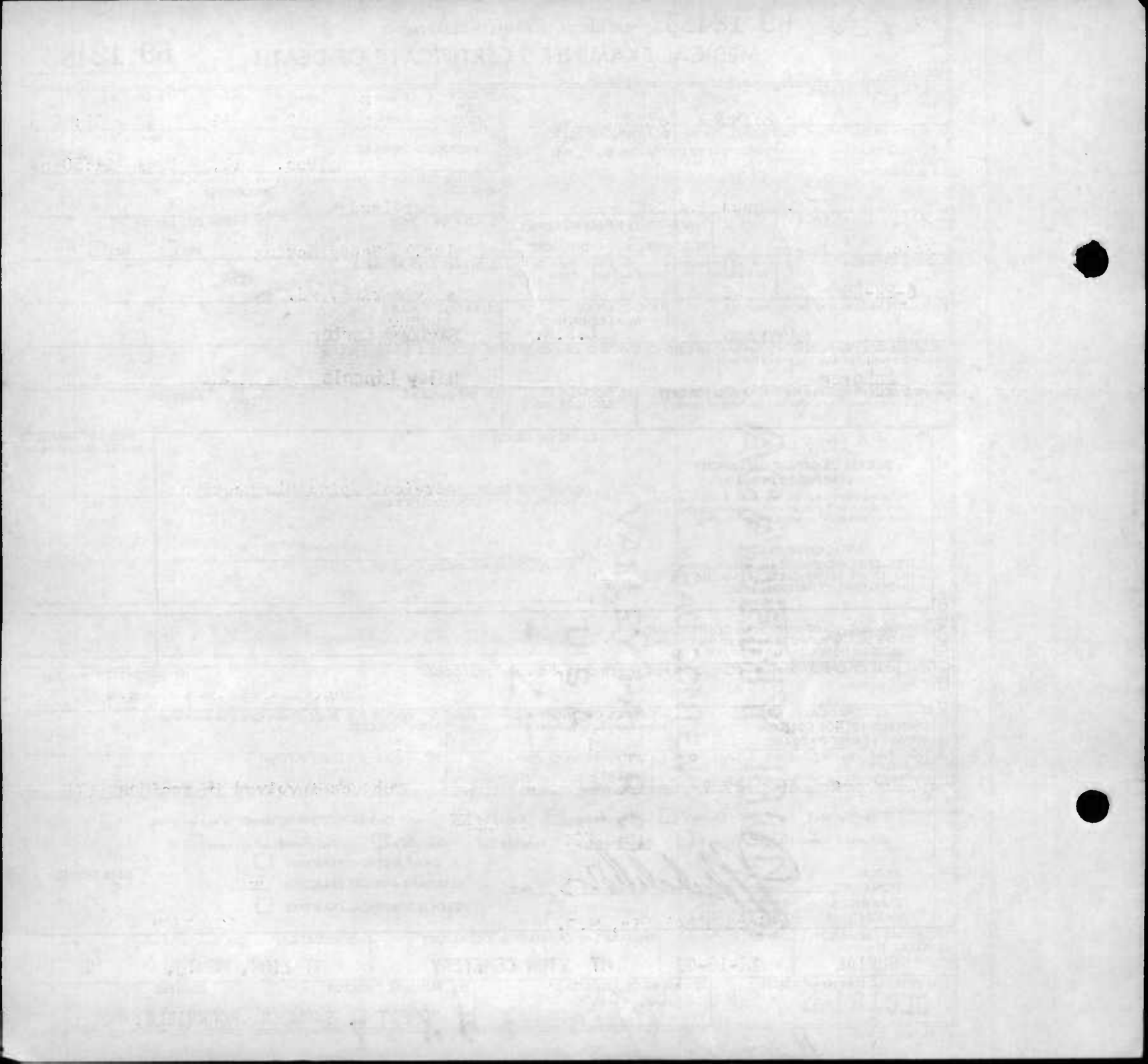
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

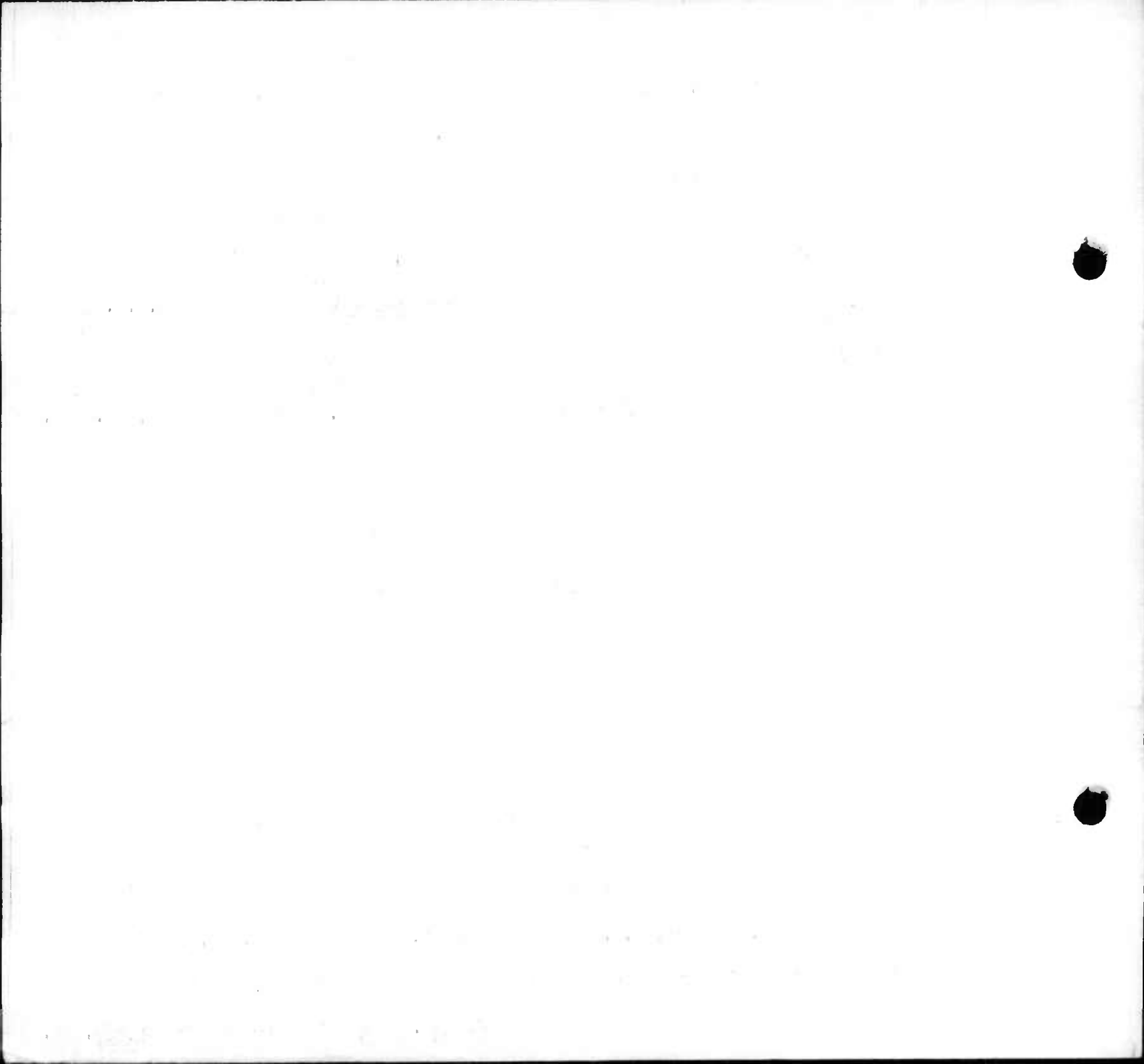
69 12483

BIRTH NO.		2. DATE OF DEATH		Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>	Month	Day	Year	Hour
1. NAME OF DECEASED (Type or Print) RAYMOND CARTER		3. DATE PRONOUNCED DEAD		Month		Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) St. Agnes Hospital		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		A. STATE		B. COUNTY		
6. SEX Male		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN (Balto.) Sandy Spring		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
9. DATE OF BIRTH 6-22-26		10. AGE (In years last birthday) 43		If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER Sandy Spring, Md.		
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eugene Raymond Carter		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		15. MOTHER'S MAIDEN NAME Haley Lincoln
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT		ADDRESS		
19. CAUSE OF DEATH								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) (A) IMMEDIATE CAUSE Cervical Spine Dislocation DUE TO, OR AS A CONSEQUENCE OF:								
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) DUE TO, OR AS A CONSEQUENCE OF:								
(C)								
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).								
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED						21. AUTOPSY? (Yes or No) YES
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) ?		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? ?				
22D. TIME OF INJURY (APPROX.) Month Day Year Hour 12 10 69 ? m.		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? Subject involved in accident (?)				
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Isidore Mihalakis, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/12/69
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-16-69		24C. NAME of CEMETERY or CREMATORY MT ZION CEMETERY		24D. LOCATION (City, town, or county) (State) MT ZION, MONTG, MD		
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969		25B. NAME OF REGISTRAR Robert E. Fisher, M.D.		25C. FUNERAL DIRECTOR ROBERT L. SNOWDEN		ADDRESS ROCKVILLE, MD		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

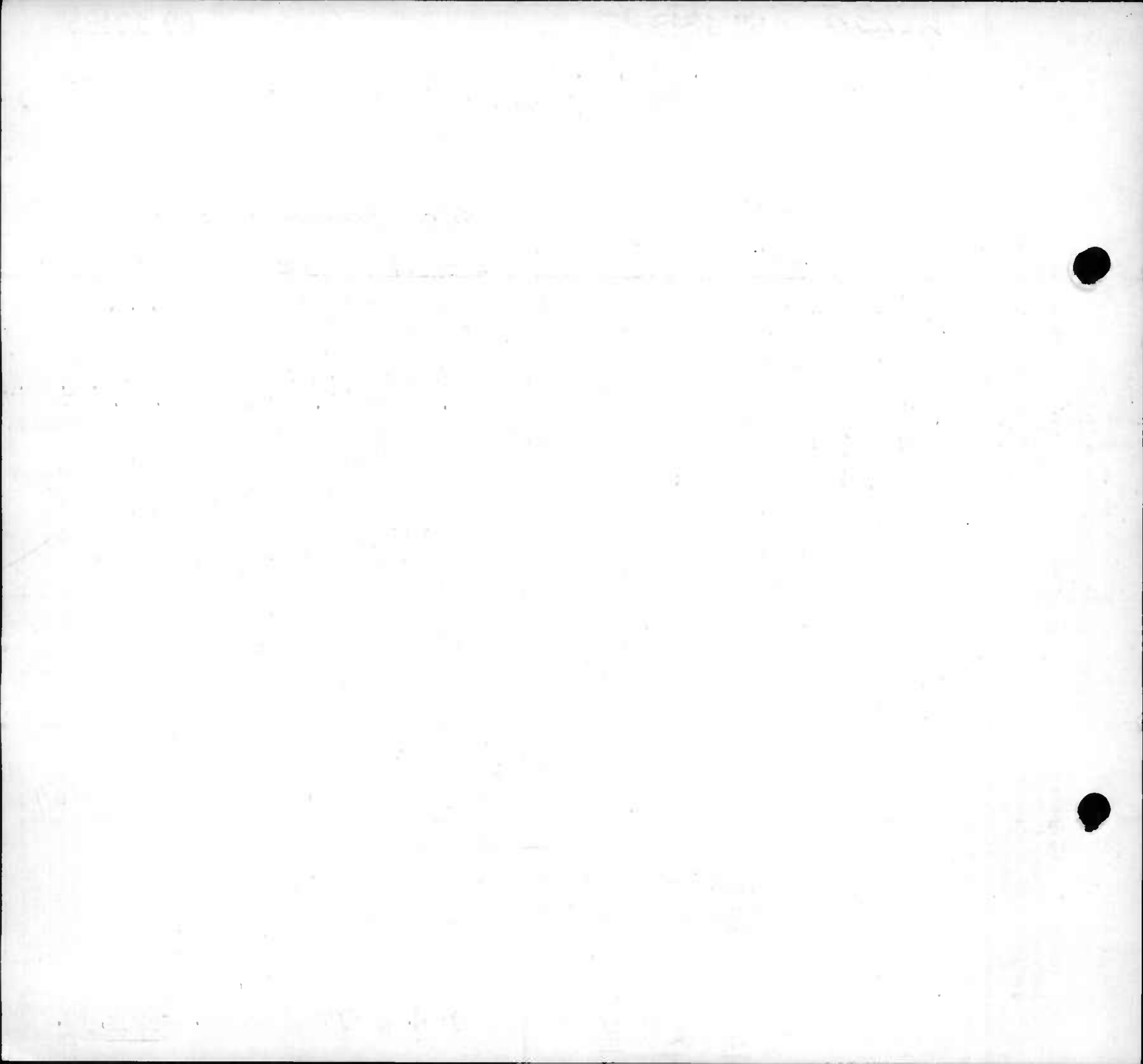
P-600		69 12484		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		69 12484	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		Mathilda M. Pora		December 14, 1969					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md.		B. COUNTY Baltimore			
Baltimore City Hospitals				C. CITY OR TOWN Edgemere		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
31				E. STREET AND NUMBER 6708 North Point Road					
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1917	9. AGE (In years last birthday) 52	10. Under 1 Yr. Months: Days:	11. Under 24 Hrs. Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Michael Michaelson			14. MOTHER'S MAIDEN NAME Suzanne Haggaduch						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 579-38-9540		17. INFORMANT Daughter: 20028 7212 Donnell Place Miss Jeanette M. Pora Forestville, Md. Apt. D6				
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Congestive Heart Failure		7 days.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:		Hypertension & Art. Scl. C.V. Dis.		10 yrs.	
				(C) DUE TO, OR AS A CONSEQUENCE OF:		Rheumatic Heart Dis. Inactive		35 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan 15 1969 to Dec 14 1969 that (I) (we) last saw the deceased alive on Dec 12 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Roger G. Windsor, M.D.				23B. DATE SIGNED 12/16/69					
23C. PHYSICIAN'S NAME (Type) Roger G. Windsor, M.D.				23D. ADDRESS 520 D St. Sparrows Point, Md. 21219					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12/18/69		24C. NAME OF CEMETERY or CREMATORY Arlington National		24D. LOCATION (City, town, or county) (State) Arlington, Virginia			
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 7922 Wise Avenue Dundalk, Md.			



FUNERAL DIRECTOR: IMPORTANT

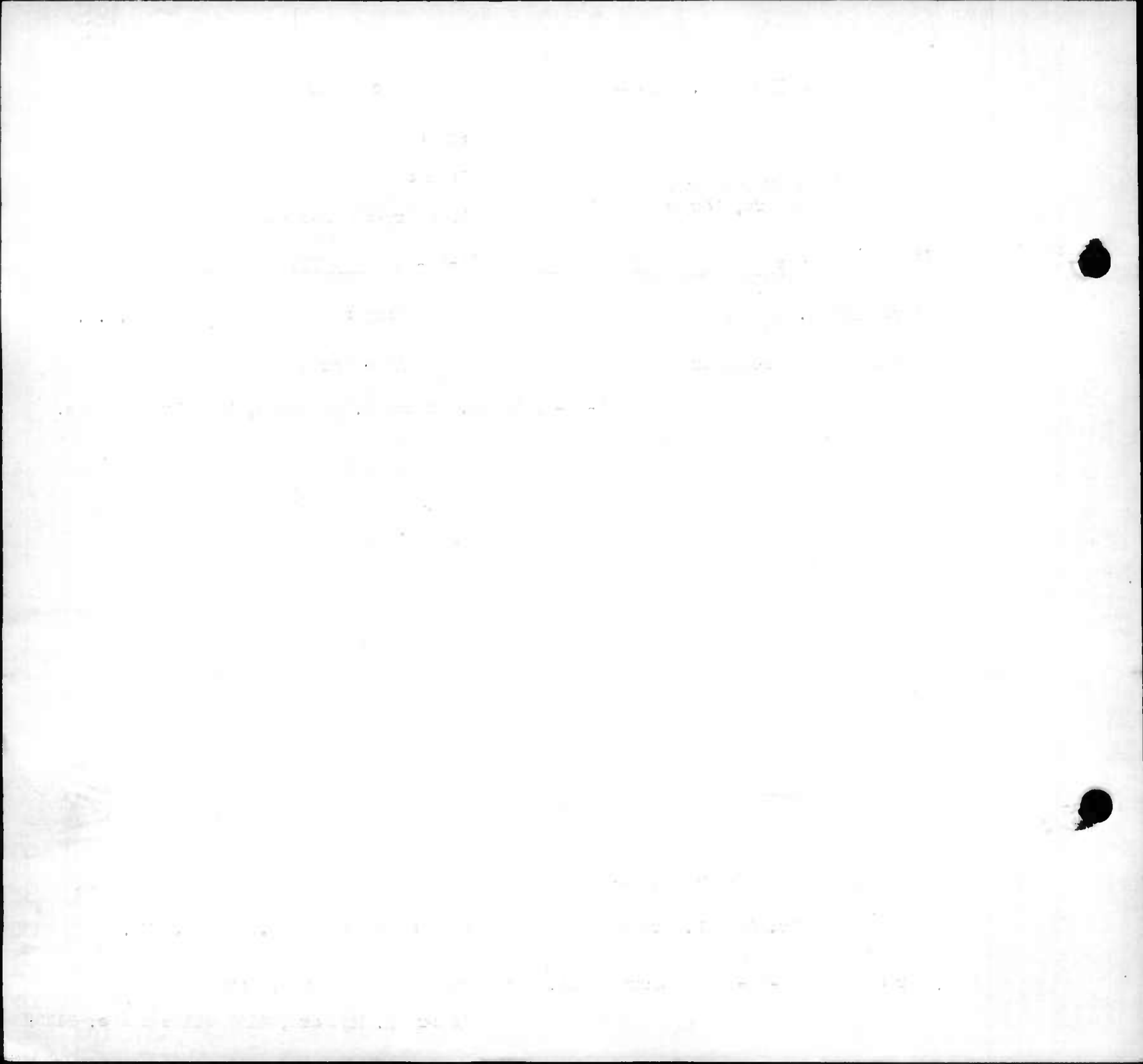
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. B-620		69 12485		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		745/A M.	
1. NAME OF DECEASED (Type or Print) Albert J. Borza, Sr.				2. DATE AND HOUR OF DEATH 12-15-69							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 2005				C. CITY OR TOWN BALTO D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Male				6. RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 6-5-15				9. AGE (in years last birthday) 54				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer			
11. BIRTHPLACE (State or foreign country) Pennsylvania				12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Martin Borza			
14. MOTHER'S MAIDEN NAME				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 225-10-2529			
17. INFORMANT Daughter: Mrs. Patricia L. Badinger				ADDRESS 3204 Old N. Pt. Rd. Balt. Md. 21222							
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Acute Myocardial Infarction				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 days few years			
19. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).											
19A. DATE OF OPERATION D				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 12/1 19 69 to 12/15 19 69 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 12/15 19 69 and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.											
23A. SIGNATURE M. Abbas MD				23B. DATE SIGNED 12/15/69				23C. PHYSICIAN'S NAME (Type) M. Abbas			
23D. ADDRESS Bon Secours Hosp.											
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12/18/69				24C. NAME OF CEMETERY or CREMATORY Glen Haven Cemetery			
24D. LOCATION (City, town, or county) Glen Burnie, Maryland											
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969				25B. NAME OF REGISTRAR Rebecca E. ...				25C. FUNERAL DIRECTOR John J. Duda			
ADDRESS 7922 Wise Ave. Dundalk, Md. 21222											



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

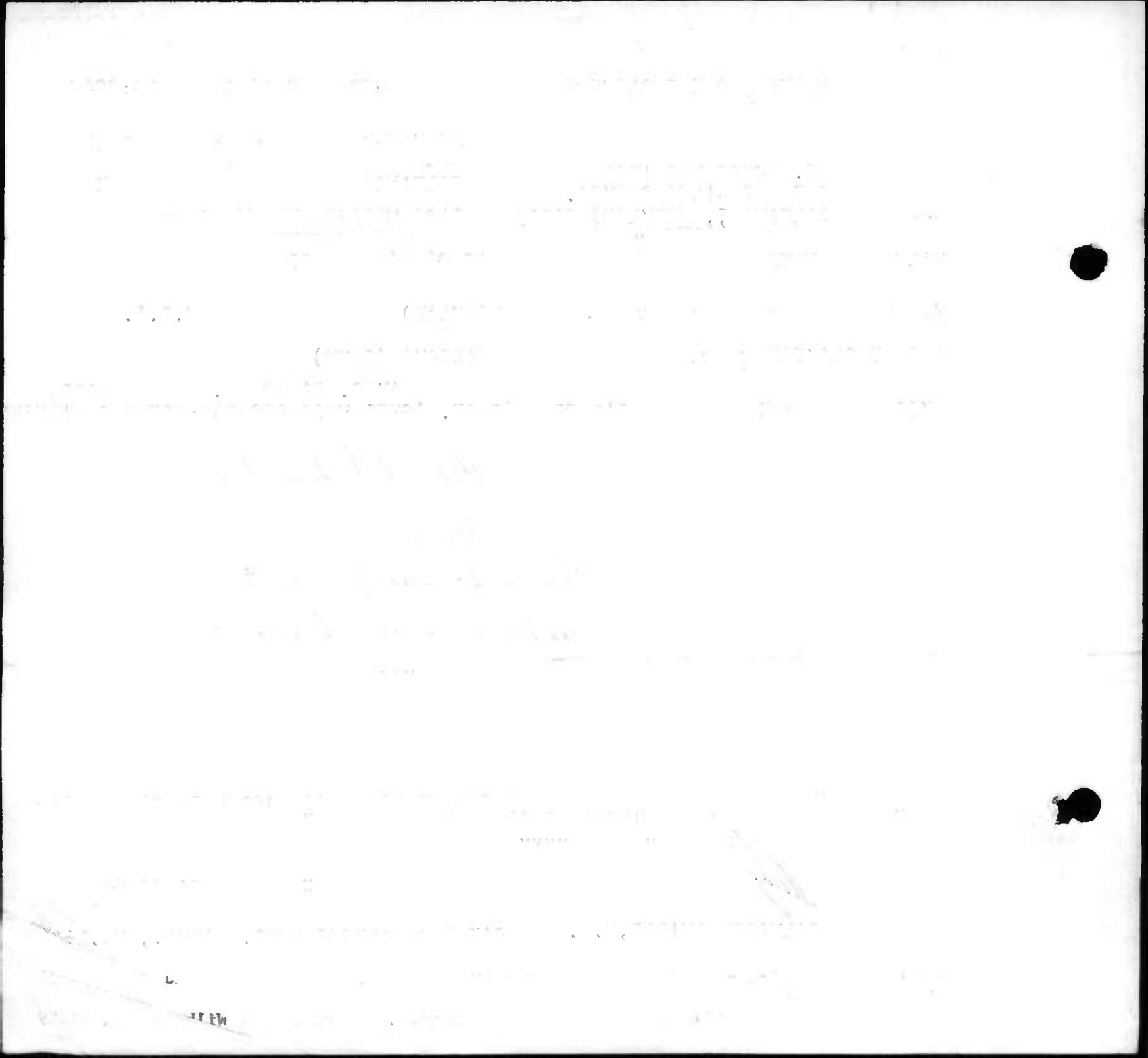
<p>P-460 69 12486 BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>		<p>REG. NO. 69 12486</p>	
<p>BIRTH NO.</p>		<p>1. NAME OF DECEASED (Type or Print) LOUISE W. PULLER</p>	
<p>2. DATE AND HOUR OF DEATH December 15, 1969 6:10 A M.</p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>	
<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2572</p>		<p>5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2503 Brohawn Avenue Baltimore, Maryland 21230</p>	
<p>6. CITY OR TOWN Lakeland</p>		<p>7. D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>8. STREET AND NUMBER 2503 Brohawn Avenue</p>		<p>9. SEX Female</p>	
<p>10. RACE White</p>		<p>11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	
<p>12. DATE OF BIRTH 12-29-91 77</p>		<p>13. AGE (In years last birthday) 77</p>	
<p>14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Pract. Nurse</p>		<p>15. KIND OF BUSINESS OR INDUSTRY</p>	
<p>16. BIRTHPLACE (State or foreign country) Maryland</p>		<p>17. CITIZEN OF WHAT COUNTRY? U.S.A.</p>	
<p>18. FATHER'S NAME Ferdinand Heinegger</p>		<p>19. MOTHER'S MAIDEN NAME Anna Marie Beck</p>	
<p>20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No</p>		<p>21. SOCIAL SECURITY NO. 217-34-3541</p>	
<p>22. INFORMANT Mr. Ernest C. Emmerich, 2503 Brohawn Ave.</p>		<p>23. ADDRESS</p>	
<p>24. CAUSE OF DEATH</p>		<p>25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>		<p>(A) IMMEDIATE CAUSE <i>Severe Cerebral Thrombosis 7 months</i> DUE TO, OR AS A CONSEQUENCE OF: <i>right internal Carotid Artery</i> (B) <i>and Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: (C) _____</p>	
<p>26. MEDICAL CERTIFICATION</p>		<p>27. DATE OF OPERATION</p>	
<p>28. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>29. AUTOPSY? (Yes or No)</p>	
<p>30. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>31. DATE OF OPERATION</p>	
<p>32. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>35. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)</p>	
<p>36. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>37. HOW DID INJURY OCCUR?</p>	
<p>38. I certify that (I) (this hospital) attended the deceased from 2/15 1955 to 12/15 1969, that (I) (we) last saw the deceased alive on 12/13 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>39. SIGNATURE <i>John P. Urlock Jr MD</i></p>		<p>40. DATE SIGNED 12/16/69</p>	
<p>41. PHYSICIAN'S NAME (Type) Dr. John P. Urlock Jr</p>		<p>42. ADDRESS 1227 Washington Blvd., Balto., Md.</p>	
<p>43. BURIAL CREMATION, REMOVAL (Specify) Burial</p>		<p>44. DATE 12-18-69</p>	
<p>45. NAME OF CEMETERY or CREMATORY Lorraine Park Cemetery</p>		<p>46. LOCATION (City, town, or county) (State) Woodlawn, Maryland</p>	
<p>47. DATE REC'D BY HEALTH DEPT. DEC 18 1969</p>		<p>48. NAME OF REGISTRAR Robert E. Taylor Jr</p>	
<p>49. FUNERAL DIRECTOR Howard H. Hubbard</p>		<p>50. ADDRESS 4107 Wilkens Ave. 21229</p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-635		BALTIMORE CITY HEALTH DEPARTMENT		69 12487	
BIRTH NO.		69 12487		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MORTON, ROBERT CLAYTON		DECEMBER 14 1969 10:00AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL CATON & WILKENS AVES. BALTIMORE, MARYLAND 21229		A. STATE & COUNTY MARYLAND Baltimore 21229			
C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER 4406 HOOPER AVENUE 21229		53-00			
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 06 96	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accountant		10B. KIND OF BUSINESS OR INDUSTRY Koppers Co.		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME ROBERT CLAYTON MORTON		14. MOTHER'S MAIDEN NAME MINERVA (CRUM)		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 212 07 9863		17. INFORMANT AVES. BALTO MD. 21229	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		18. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial Infarction (B) Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (C) Cerebrovascular Accident Cirrhosis of the Liver -			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 06 19 69 to DECEMBER 14 19 69 that (X) (we) lost saw the deceased alive on DECEMBER 14 19 69 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXX) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED 12 14 69		23C. PHYSICIAN'S NAME (Type) SALVADOR QUIROZ, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-18-69		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkens Ave. 21229			



S-530

69 12488

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12488

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)James
Ernest P. Smith Jr.2. DATE OF DEATH
Known ☒ Estimated ☐
Month Day Year Hour M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)
2831 Georgetown Rd. 1-14-703. DATE PRONOUNCED DEAD
Month Day Year Hour M.
12 12 69 5:45 p. M.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
A. STATE B. COUNTY

Maryland 2582

6. SEX

male

7. RACE

white

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐ NO ☐

9. DATE OF BIRTH

Sept. 4, 1925

10. AGE (In years
last birthday)

44

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

X X X

E. STREET AND NUMBER

2831 Georgetown Rd.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF
WHAT COUNTRY?

U.S.

13. FATHER'S NAME

Ernest Smith

14A. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

14B. KIND OF BUSINESS OR INDUSTRY

Carpenter

15. MOTHER'S MAIDEN NAME

Irene Grey

16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL
SECURITY NO.

213-200354

18. INFORMANT

ADDRESS

Mrs E.J. Smith, Georgetown Rd-212287

19.

E 966X

2 CAUSE OF DEATH

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asphyxia, etc. It means the disease,
injury or complication which caused death.)(A) IMMEDIATE CAUSE Stab wound of chest
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE TERMINAL
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS
UNDERLYING OR CONTRIBUTING
CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about
home, farm, factory, street, office bldg., etc.)
home22C. WHERE DID (If in Baltimore City, give exact location)
INJURY OCCUR?
2831 Georgetown Rd. 258222D. TIME OF INJURY (Month) (Day) (Year) (Hour)
(APPROX.) 12 12 69 5:18p m.22E. INJURY OCCURRED
WHILE AT WORK ☐ NOT WHILE AT WORK ☒22F. HOW DID INJURY OCCUR?
stabbed during altercation

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL
SIGNATURE
EXAMINER'S
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

Deputy Chief Medical Examiner 12/13/69

24A. BURIAL CREMATION,
REMOVAL (Specify)

Burial

24B. DATE

12-17-69

24C. NAME OF CEMETERY or CREMATORY

Good Shepherd

24D. LOCATION (City, town, or county) (State)

Ellicott City Md.

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, R.D.

25C. FUNERAL DIRECTOR

ADDRESS

301 Frederick Rd. 21228

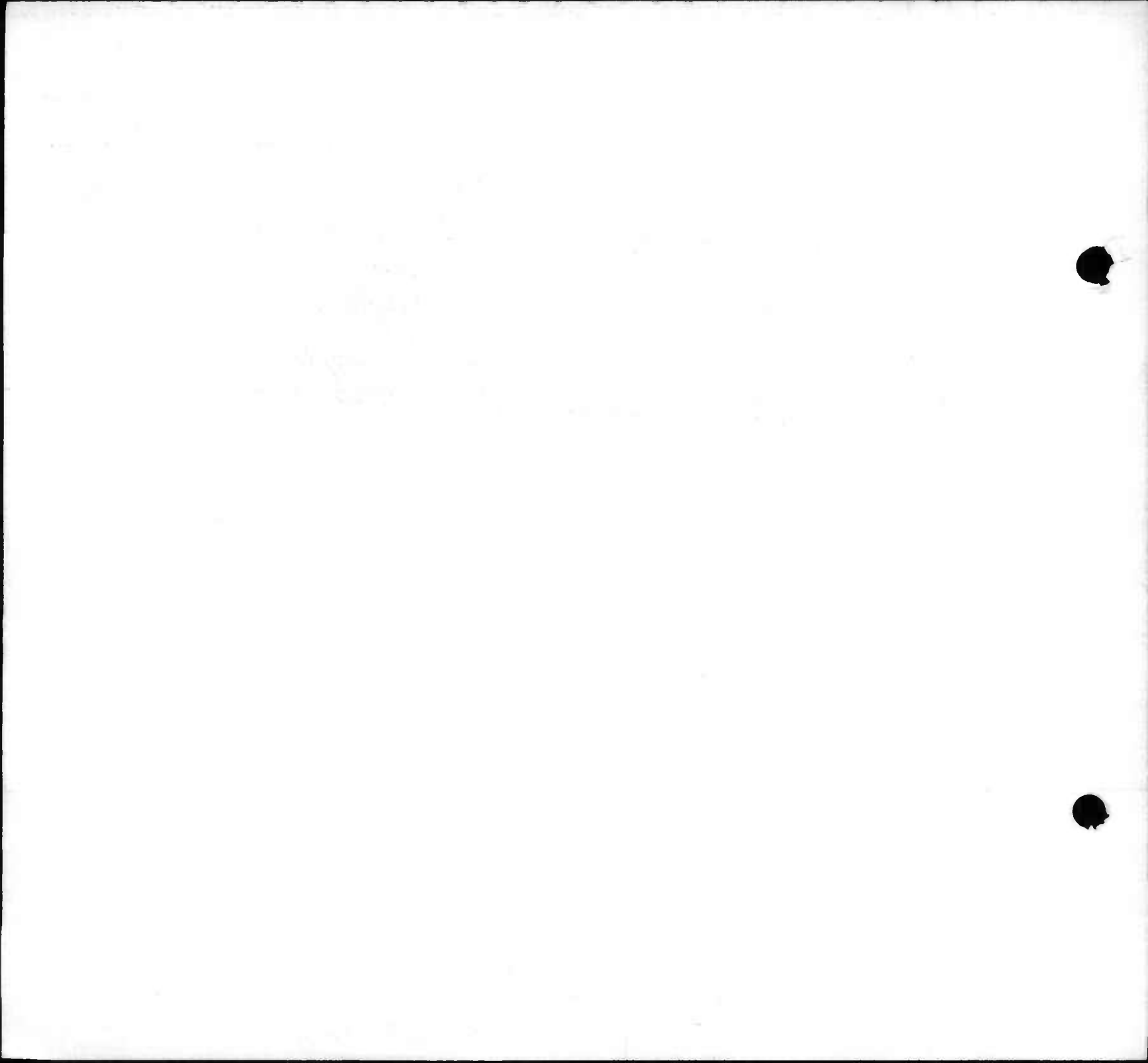
ACADEMY OF OND

HIS CONTENT

VALLEY PARKER 90

NO 4

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12480	
1-656		69 12480	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Durner Margaret M.		2. DATE AND HOUR OF DEATH 12-16-69 6 25 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION North Charles General Hospital		A. STATE Maryland B. COUNTY 2130 2403 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER Harbor View Nursing Home F. LIGHT STREET	
5. SEX F	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-8-1985
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10B. KIND OF BUSINESS OR INDUSTRY AT Home	9. AGE (In years last birthday) 84
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-01-0406	
17. INFORMANT NCCH. chart Amelia H. Durner		ADDRESS 8609 Wendell Ave	
18. 410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) CORONARY THROMBOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12-11-1969 to 12-16-1969 , that (I) (we) last saw the deceased alive on 12-16-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Victor Salama M.D.		23B. DATE SIGNED 12/16/69	
23C. PHYSICIAN'S NAME (Type) VICTOR SALAMA M.D.		23D. ADDRESS North Charles General Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 12-19-1969	
24C. NAME OF CEMETERY or CREMATORY Holy Redeemer Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR CHAS. F. F. Evans Son		ADDRESS 8802 Hartford Rd	



S-421

69 12491

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

69 12491

BIRTH NO.

1. NAME OF DECEASED
(Type or Print)

Charles Shelsby

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD
FULL NAME OF HOSPITAL OR INSTITUTION
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

35 Church Home and Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour
12 15 69 5:52 p.m.5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
A. STATE B. COUNTY

Maryland

201

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☒

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

10/8/1900

10. AGE (In years last birthday)

69

If Under 1 Yr. If Under 24 Hrs.
Months Days Hours Min.

E. STREET AND NUMBER

2033 Gough St.

11. BIRTHPLACE (State or foreign country)

D.C. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Charles R. Shelsby

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Carpenter

14B. KIND OF BUSINESS OR INDUSTRY

Self Employed

15. MOTHER'S MAIDEN NAME

Emma Bernice Johnson

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL SECURITY NO.

219-28-8622A

18. INFORMANT

Mrs Emma Smith

ADDRESS

225 S. Mount St.

19.

204,91

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Lymphocytic leukemia
DUE TO, OR AS A CONSEQUENCE OF:

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

no

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

Deputy Chief Medical Examiner

DATE SIGNED

12/16/69

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

12/19/69

24C. NAME OF CEMETERY or CREMATORY

Green Haven Cem.

24D. LOCATION (City, town, or county) (State)

Green Haven

25A. DATE REC'D BY HEALTH DEPT.

DEC 18 1969

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

25C. FUNERAL DIRECTOR

J. H. ...

ADDRESS

901 ... St.

10181 83

STATE OF CALIFORNIA - DEPARTMENT OF AGRICULTURE

ACADEMY OF AGRICULTURE

DEPARTMENT OF AGRICULTURE

STATE OF CALIFORNIA

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-200		69 12492		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12492	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) JAMES DIX <i>James Dix</i>				2. DATE AND HOUR OF DEATH <i>12. 17. 69 11 30 A.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>201</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>North Charles General Hosp</i> <i>49</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>Balto</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>Caucasian</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>11-8-99</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Police Officer</i>		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) <i>70</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Frank Dix</i>				14. MOTHER'S MAIDEN NAME <i>Sophie Levandoski</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES World War I (Marine)</i>		16. SOCIAL SECURITY NO. <i>18-36-1539</i>		17. INFORMANT <i>Edward Dix</i>		ADDRESS <i>3401 Richmond Ave.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>151.9 I</i> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Massive Gastric Bleeding</i> (B) <i>Gastric Malignancy</i> (C) _____			
MEDICAL CERTIFICATION							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>12-15-69</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Laparotomy + Biopsy of Duodenum</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>we</u> (this hospital) attended the deceased from <i>Dec. 2</i> 19 <i>69</i> to <i>Dec. 17</i> 19 <i>69</i> , that (I) <u>we</u> last saw the deceased alive on <i>Dec 17</i> 19 <i>69</i> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> <u>(did)</u> (did not) view the body after death.							
23A. SIGNATURE <i>Marguerita Cansino - Senior</i>				23B. DATE SIGNED <i>12-17-69</i>		23C. PHYSICIAN'S NAME (Type) <i>MARGUERITA CANSINO - U.M.M.D.</i>	
23D. ADDRESS <i>North Charles Gen. Hospital</i>				23E. FUNERAL DIRECTOR'S ADDRESS <i>Lilly & Zeiler Inc. 1901-07 Eastern Ave.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-20-1969</i>		24C. NAME of CEMETERY or CREMATORY <i>Holy Rosary</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore County, Maryland</i>	

James Foster, Esq.
Boston, Mass.

12-12-81
No. 10

Dec 17 1881

✓
12-17-81
Margaret Cannon
Marionette Cannon in and out of hospital

FUNERAL DIRECTOR: IMPORTANT

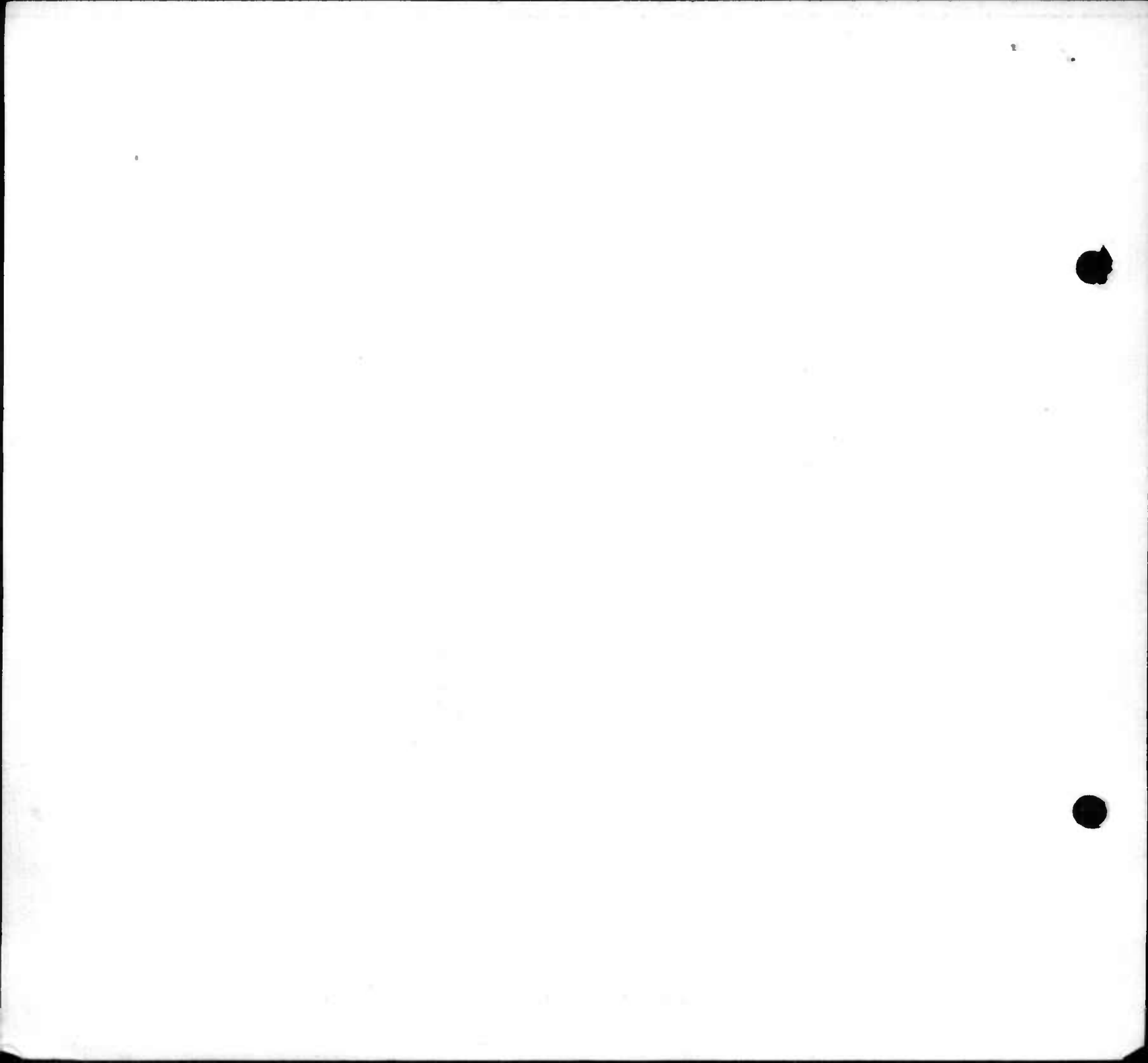
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

E-163		69 12493		BALTIMORE CITY HEALTH DEPARTMENT		69 12493	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) JOHN A. EVERD <i>EVERD Mr John</i>				2. DATE AND HOUR OF DEATH 12.17.1969 <i>4.25 a.m.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Church Home and Hospital</i> <i>100 N Broadway Baltimore Md. 21231</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? <i>202</i> <i>240 S. Durham St.</i> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>240 S. Durham Street.</i>			
5. SEX <i>male</i>	6. RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8.8.1916</i>	9. AGE (in years last birthday) <i>53 yr.</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Nicholas Everd</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Zebelman</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <i>911-18-4136</i>		17. INFORMANT <i>Roger Everd</i> ADDRESS <i>same as his</i>			
18. <i>571.9 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <i>12-14-1969</i> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (H) (this hospital) attended the deceased from <i>12.14.1969</i> to <i>12-17-1969</i> that (I) (we) last saw the deceased alive on <i>12-16-1969</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <i>Abdur Samad</i> MD DEGREE <i>MD</i> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> 23B. DATE SIGNED <i>12/17/69</i> 23C. PHYSICIAN'S NAME (Type) <i>ABDUS SAMAD MD</i> 23D. ADDRESS <i>240 S Durham Street</i>							
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>12-20-1969</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Carmel</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>DEC 18 1969</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Lilly & Zeiler Inc.</i>		ADDRESS <i>1901-07 Eastern Ave.</i>	

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

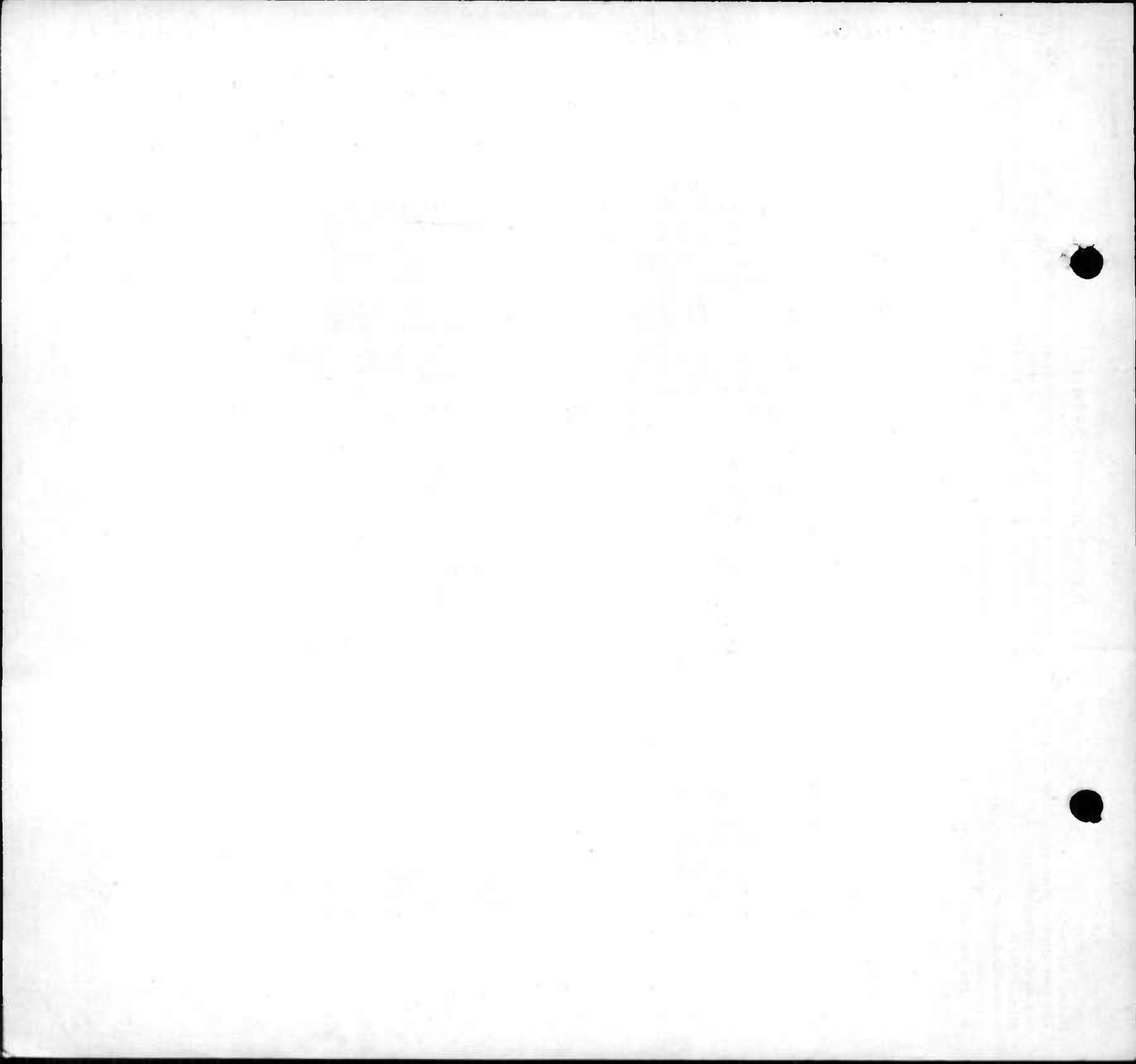
S-350 69 12494		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12494	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>CORA LEE SUTTON</u>		2. DATE AND HOUR OF DEATH <u>12-16-69</u> <u>5:48 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>8 UNIV. HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>1901</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>331 N. CALHOUN ST</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-17-19</u>	9. AGE (In years last birthday) <u>49</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>NC</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Stance Cassidy</u>		14. MOTHER'S MAIDEN NAME <u>Annie Corrington</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>M</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>James T. Green</u>	
18. <u>426 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Primary Pulmonary Hypertension</u> <u>Cardiac Arrest</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/14</u> 19 <u>69</u> to <u>12/16</u> 19 <u>69</u> and that (I) (we) last saw the deceased alive on <u>12/16</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Larry Schlossberg MD</u>		23B. DATE SIGNED <u>12-16-69</u>			
23C. PHYSICIAN'S NAME (Type) <u>BARRY SCHLOSSBERG MD</u>		23D. ADDRESS <u>UNIV. HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>12-17-69</u>		24C. NAME OF CEMETERY or CREMATORY <u>Carmen Cut</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1969</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>Joseph M. Wilson</u>	
				ADDRESS <u>1001 Brimley Ave</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

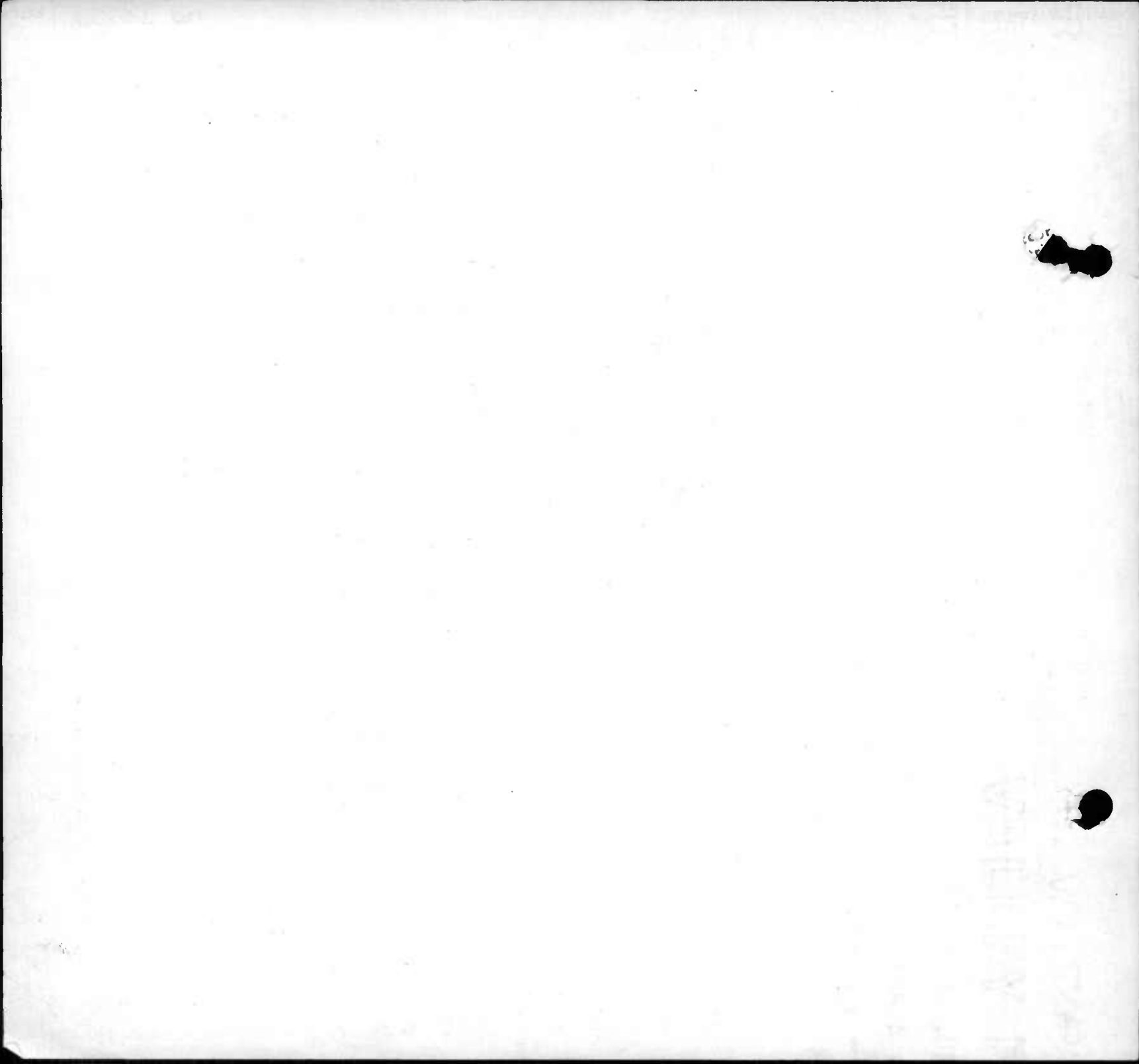
55-64-15				H-400		69 12495		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12495	
BIRTH NO.								CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) GEORGE HALLOWAY JR						2. DATE AND HOUR OF DEATH December 13, 1969 7:15 A.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 13					
FULL NAME OF HOSPITAL OR INSTITUTION 31 BALTIMORE CITY HOSPITAL 4940 Eastern Avenue Baltimore, Maryland 21224						C. CITY OR TOWN Baltimore			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER 33631 GELSTON DRIVE											
5. SEX Male		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/6/07		9. AGE (In years last birthday) 62		10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED						10B. KIND OF BUSINESS OR INDUSTRY RETIRED			11. BIRTHPLACE (State or foreign country) South Carolina		
12. CITIZEN OF WHAT COUNTRY? U. S.											
13. FATHER'S NAME SILAS HALLOWAY						14. MOTHER'S MAIDEN NAME ELIZA Freeman					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No						16. SOCIAL SECURITY NO. 249-28-7354		17. INFORMANT 4940 Eastern Avenue BCH: Records Baltimore, Maryland 21224			
18. 162.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) MASSIVE SUDDEN PULMONARY HEMORRAGE						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. CARCINOMA OF THE LUNG SUPERIOR VENA CAVA SYND.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). COPD											
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from DEC 9 19 69 to DEC. 14 19 69 , that (I) (we) last saw the deceased alive on DEC. 14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Jaime F. Casellas						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 12/14/69			
23C. PHYSICIAN'S NAME (Type) JAIME F. CASELLAS						23D. ADDRESS 4940 EASTERN AVE BALTO MD. 21224					
24A. BURIAL CREMATION REMOVAL (Specify) Burial				24B. DATE 12-18-69		24C. NAME OF CEMETERY OR CREMATORY Putnam Cent		24D. LOCATION Balto		(City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969				25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Shay [Signature]					



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650 69 12496				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12496	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) BROWN, FRED			
2. DATE AND HOUR OF DEATH 12-12-69 9⁰⁰ A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission) A. STATE MARYLAND B. COUNTY 1602				FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) LUTHERAN			
C. CITY OR TOWN BALTO				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER 1122 WHATCOAT ST.				S. SEX M 6. RACE N 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 3-9-08				9. AGE (In years last birthday) 61			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10B. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) North Carolina				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME John Brown				14. MOTHER'S MAIDEN NAME Jane Torrance			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Willie L. Brown				ADDRESS			
18. 437.9 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cerebro vascular accident 10.3.69			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Cerebro-arteriosclerosis 12.12.69			
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? <input checked="" type="checkbox"/> Yes or <input type="checkbox"/> No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (it) (this hospital) attended the deceased from 10.3.69 19 to 12-12- 19 69 , that (I) (we) last saw the deceased alive on 12.11. 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE P. G. Naneswaran M.D.				23B. DATE SIGNED 12.12.69			
23C. PHYSICIAN'S NAME (Type) P. G. NANESWARAN				23D. ADDRESS Lutheran Hosp. 730 Ashburton St. Balto.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 12-12-69			
24C. NAME OF CEMETERY or CREMATORY St. Luke's				24D. LOCATION (City, town, county) (State) Balto Md			
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969				25B. NAME OF REGISTRAR John E. Brown			
25C. FUNERAL DIRECTOR John E. Brown				ADDRESS			



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D-200		69 12497		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 69 12497	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) ERNEST LINWOOD DIGGS JR				2. DATE AND HOUR OF DEATH DEC 14 1969 1 5:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 802			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) JOHNS HOPKINS HOSPITAL 33				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 2339 E. NORTH AVE			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-26-55	9. AGE (In years last birthday) 14	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Balto. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNEST DIGGS, SR.				14. MOTHER'S MAIDEN NAME GLORIA REDD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO.		17. INFORMANT Hennetta Diggs Same			
18. 207.9 I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ASPIRATION, CEREBRAL INFARCT				2 HRS			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) LEUKEMIA DUE TO, OR AS A CONSEQUENCE OF:			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (usually medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 4:30 PM 12/14 19 69 to 5:30 PM 12/14/69 that (H) (we) last saw the deceased alive on DEC 14 19 69 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Nicholas A. Volpicelli				23B. DATE SIGNED Dec 14, 1969		23C. PHYSICIAN'S NAME (Type) NICHOLAS A. VOLPICELLI M.D.	
23D. ADDRESS THE JOHNS HOPKINS HOSPITAL							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-18-69		24C. NAME OF CEMETERY or CREMATORY Not known		24D. LOCATION (City, town, or county) (State) Balt Md	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969		25B. NAME OF REGISTRAR John A. 9 0 0		25C. FUNERAL DIRECTOR Raymond Brantley		ADDRESS	

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S-315 69 12498

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 69 12498

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Elsie Stevenson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/>		Month	Day	Year	Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 14 N. Dallas St.		3. DATE PRONOUNCED DEAD Month 12 Day 13 Year 69		Hour 5:35 p.m.			
6. SEX female		7. RACE colored		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Sept 7, 1895		10. AGE (In years lost birthday) 74		11. BIRTHPLACE (State or foreign country) York, S. Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joe Walker		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Katie		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT Robert Vance		ADDRESS 809 E. 22nd St.			
19. 412.41		CAUSE OF DEATH Arteriosclerotic cardiovascular disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:					
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:					
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) No			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Werner U. Spitz, M.D. NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> Deputy Chief Medical Examiner		DATE SIGNED 12/14/69	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 12-17-69		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR George S. Wilson		ADDRESS 1000 Broadway	

20th 1892 11 2

John S. Conner N. A. 2nd Walker

Katie —

John S. Conner 20th 1892

No

ADDITIONAL

11 1892

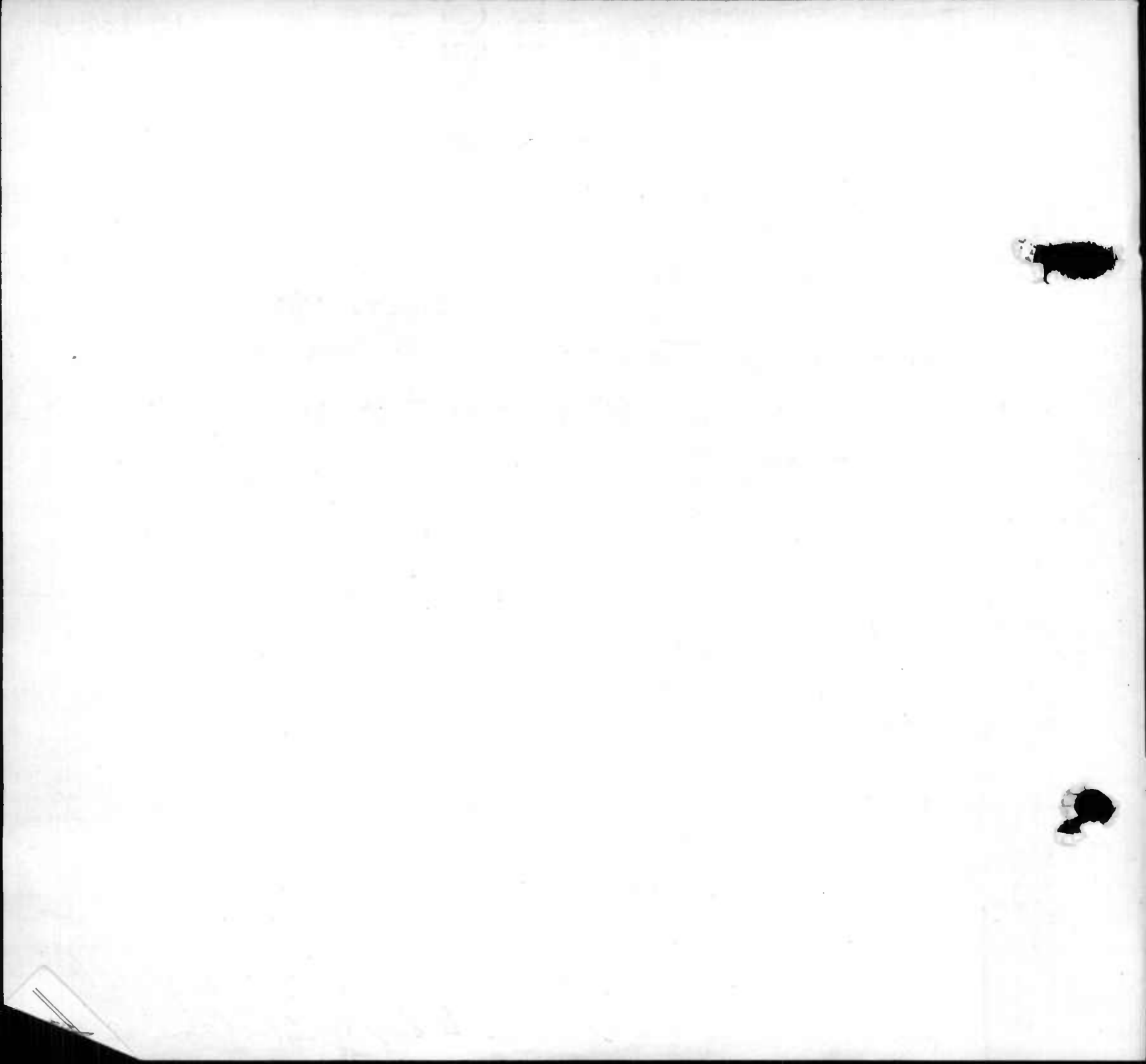
Printed 12-17-92 by T. A. Conner. Boston. 1892

Clayton & Co.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 69 12499	
J-520 69 12499				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Louise E. Jones</u>		2. DATE AND HOUR OF DEATH <u>12-14-69</u> <u>1:45</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital</u>			A. STATE <u>Maryland</u> B. COUNTY <u>1605</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>2547 W. Lankford St.</u>					
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-2-39</u>	9. AGE (In years last birthday) <u>37</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bacto. Md.</u>	
13. FATHER'S NAME <u>WILLIAM JONES</u>		14. MOTHER'S MAIDEN NAME <u>MARIAN PRATT</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-282892</u>		17. INFORMANT <u>ALBERTA BROWN</u> ADDRESS <u>9A</u>	
18. <u>45.91</u> CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Epilepsy Cerebral Contusion.</u>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
(C) _____					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-9</u> 19 <u>69</u> to <u>12-15</u> 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>12-14</u> 19 <u>69</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Violeta R. Gamarrar, M.D.</u>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>VIOLETA R. GAMARRAR, M.D.</u>				23D. ADDRESS <u>731 Ashburton St. Baltimore Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>12-14-69</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Not Baltimore City</u>	
24D. LOCATION (City, town, or county) (State) <u>Calvert County Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>DEC 18 1969</u>		25B. NAME OF REGISTRAR <u>Miss E. Tabery</u>	
25C. FUNERAL DIRECTOR <u>E. Roy O. Wilson</u>		25D. ADDRESS <u>2108</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be completed by the chief medical examiner or his assistant if death occurred in a hospital and by the funeral director if death occurred elsewhere. It must be completed by a medical examiner if death occurred in a hospital and the body was released to the funeral director. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-000		69 12500		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.		69 12500	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) ROY, MARY Gertrude (Mary C. Roy)				2. DATE AND HOUR OF DEATH 12-14-69 5-45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1505				5. CITY OR TOWN Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION 39 Provident Hospital, Inc. 1514 Division St. Baltimore, Maryland 21217				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER 3104 Reisterstown Road	
6. SEX Female	7. RACE Negro	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. DATE OF BIRTH 3-23-19	10. AGE (In years last birthday) 50	11. Under 1 Yr. Months: Days: Hours: Min.	12. Under 24 Hrs. Min.	13. CITIZEN OF WHAT COUNTRY? USA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY Home				11. BIRTHPLACE (State or foreign country) Virginia, Charlotte Co.	
13. FATHER'S NAME James Daniels				14. MOTHER'S MAIDEN NAME Mary McCargo				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No.	
16. SOCIAL SECURITY NO.				17. INFORMANT James F. Roy (Husband)				ADDRESS Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 1829 I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH ANTecedent CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). Cachaxia				(A) IMMEDIATE CAUSE Cerebral metastasis DUE TO, OR AS A CONSEQUENCE OF: Ca uterus (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH approx 1 year 8 months	
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 12-14-1969 to 12-14-1969 that (I) (we) last saw the deceased alive on 12-14-1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE M. J. Sharf			
23B. DATE SIGNED 12-14-69		23C. PHYSICIAN'S NAME (Type) M. JAVAD SHARI		23D. ADDRESS Provident Hospital		24. DATE 12-19-69			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24C. LOCATION (City, town, or county) (State) Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. DEC 18 1969			
25B. NAME OF REGISTRAR E. Taylor, M.D.		25C. FUNERAL DIRECTOR MORTON & DYETT F.H.		25D. DATE 12-19-69		25E. NAME OF REGISTRAR E. Taylor, M.D.			

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